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OHIO Medicine

JOURNAL OF THE OHIO STATE MEDICAL ASSOCIATION

VOL. 85. NO. 7 JULY 1989

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In the depressed and anxious patient

See Improvement

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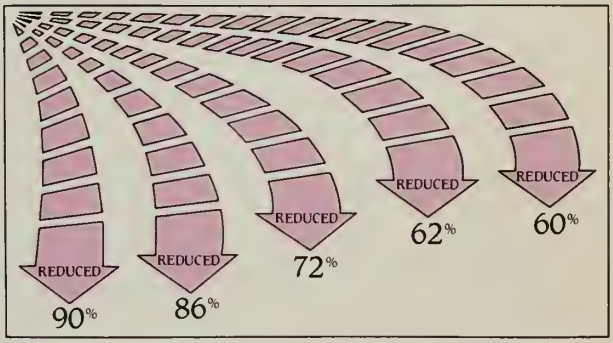
In The First Week[1]...
And The Weeks That Follow

- 74% of patients experienced improved sleep after the first *h.s.* dose[1]
- First week reduction in somatic symptoms[1]

Percentage of Reduction in Individual Somatic Symptoms During First Week of Limbitrol Therapy*



*Patients often presented with more than one somatic symptom.

Limbitrol®

Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) (IV)

Limbitrol® DS

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) (IV)

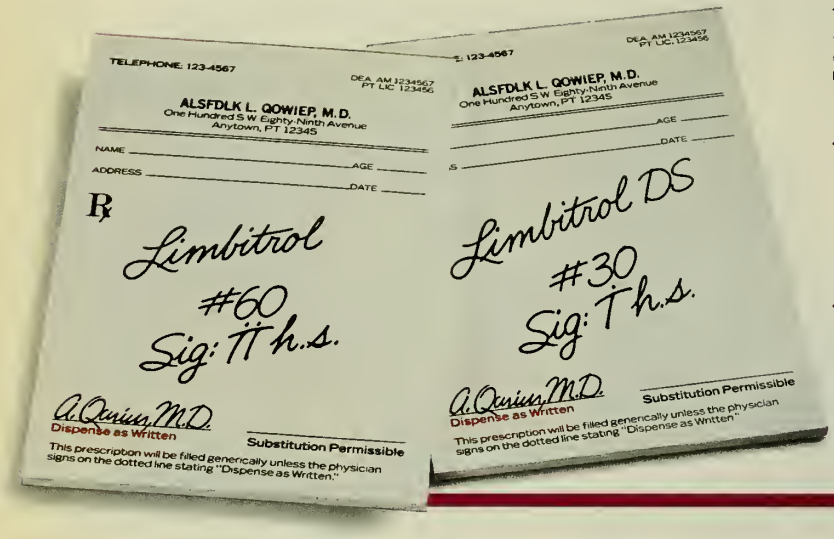
Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

ROCHE® **Roche Products**

Please see summary of product information on following page.

In moderate depression and anxiety

- 74% of patients experienced improved sleep after the first *h.s.* dose[1]
- First week improvement in somatic symptoms[1]
- 50% greater improvement with Limbitrol in the first week than with amitriptyline alone[2]



Protect Your Prescribing Decision: Specify "Do not substitute."

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Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) (IV)

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Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) (IV)

References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner JP, *et al: Psychopharmacology 61:*217-225, Mar 22, 1979.

Limbitrol® (IV)
Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.**

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. *Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. *Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. *Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. *Endocrine:* Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

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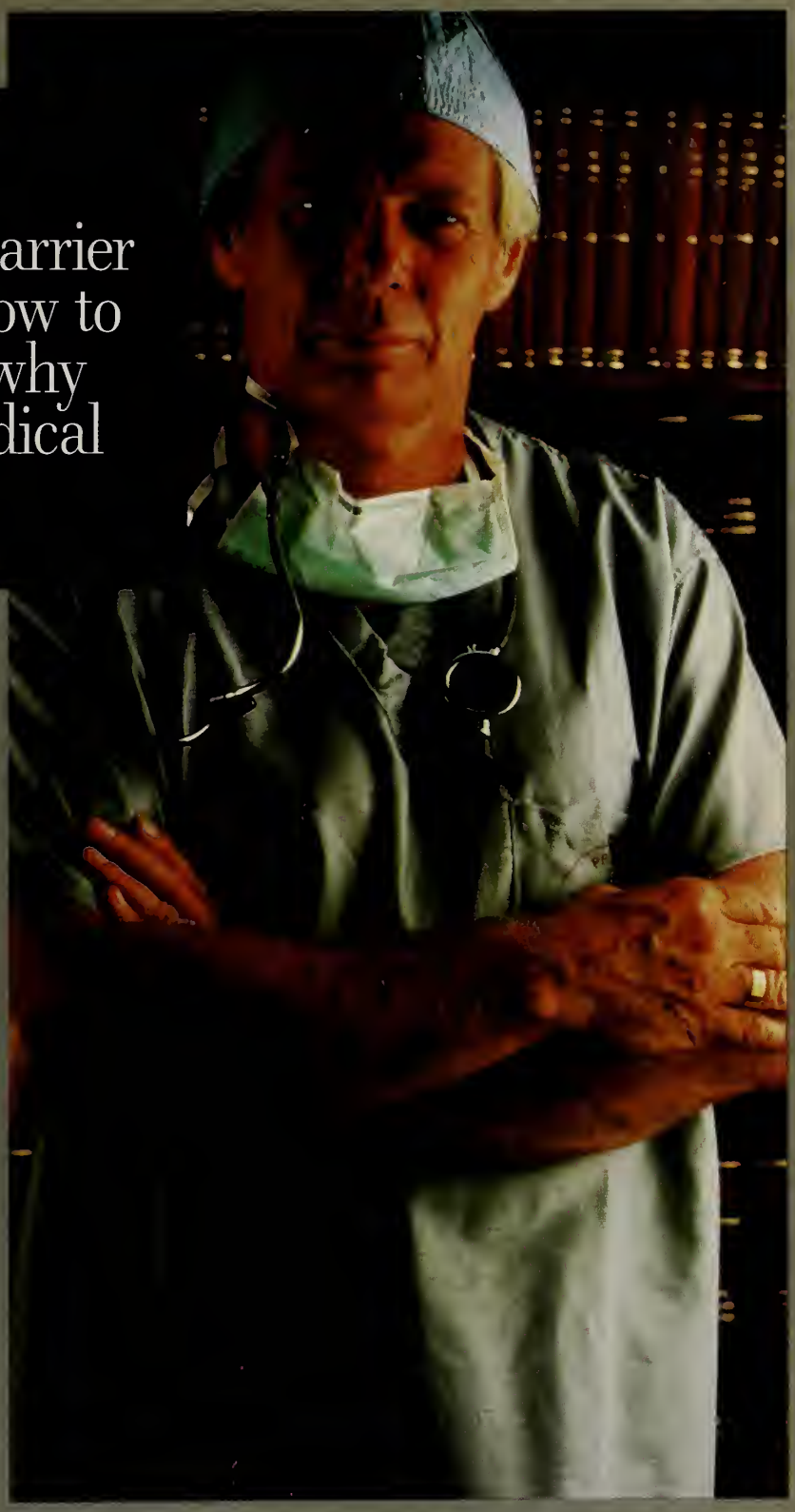

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Published monthly under the direction of The Council for and by members of OHIO Medicine, 1500 Lake Shore Drive, Columbus, Ohio 43204-3824, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1989 Subscription: $25 per year.

Send address changes to: OHIO Medicine, 1500 Lake Shore Drive, Columbus, Ohio 43204-3824.

Second Class Postage paid at Columbus, Ohio and at additional mailing offices.

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FROM THE EDITOR

Different News, Different Views...

Each year, we devote our July —sometimes our August— issue to highlighting the OSMA's Annual Meeting.

Each year, you read about the business conducted in the first session of the House, then take a look at how this year's crop of resolutions fared in the final session. And, of course, you skim the official Annual Meeting Minutes . . .

Still, there is a lot more to a typical Annual Meeting than what goes on at both sessions of the House . . . and this year, we've decided to include an article in our wrap-up issue that provides you with a more comprehensive view of the entire meeting itself. Those of you who have never attended an Annual Meeting will, if we've done our job right, come away feeling you have — and those of you who have attended past meetings (or were with us this year), should catch some glimmers of recognition. It's basic stuff — Annual Meeting 101 — an introductory course, if you will — and we gave it to staff writer and Annual Meeting novitiate Michelle Carlson to put together for you. We think you'll find her story "The OSMA Annual Meeting: See How It's Run" an interesting and informative addition to our usual Annual Meeting material.

Also in this issue . . . look for Part II of Dr. Albert May's piece on the CME Site-Survey Process and Part I of a splendid article contributed to our publication by noted lecturer and author Norman Cousins, who becomes *OHIO Medicine's* first guest editor.

"What's New" is certainly a good theme for *OHIO Medicine* this year. By now, you've noticed our new cover look — requested by Dr. Marshall during his term in office — and this issue provides you with some new and different material to read as well. In addition, we have an almost brand-new editorial board, headed by Richard Reiling, MD, of Dayton, who will ensure that your publication keeps on improving . . .

If you have comments about our new look . . . or our new contents . . . won't you please write and let us know? We'd enjoy hearing from you, and, of course, we value our readers' input . . .

Karen S. Edwards

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ISSN 0892-2454
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OUR COVER:

This month's cover "Street in Tahiti" by Paul Gauguin. Toledo Museum of Art. (See page 559 for more information about the artist.)

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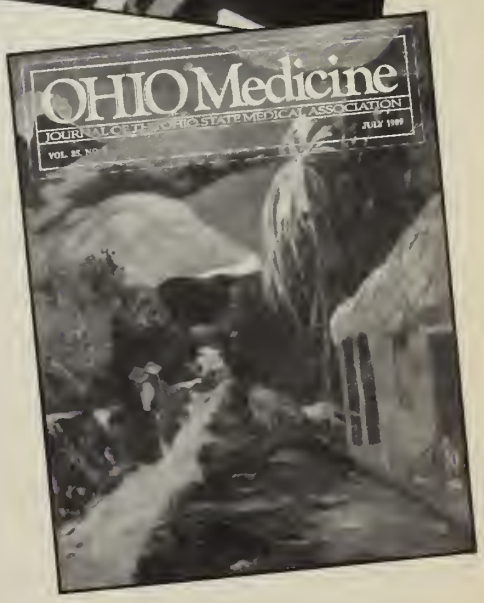

Learning From Medical Students — Part I

By Norman Cousins

One of my early assignments after coming to the UCLA School of Medicine was to lecture on literature and philosophy to medical students. The liberal arts had been downplayed in medical education. In connecting medicine to the humanities I was addressing myself to the fact that incoming students were long on science and short on the arts.

"I think you'll find that the more informal the setting, the better your rapport with medical students," Dr. Bernard Towers told me. Dr. Towers had invited me to be part of his program in "Science, Law and Human Values." He had come from England a dozen years earlier and attracted attention as a medical ethicist. He was the moderator of a medical forum at UCLA in which I participated several weeks before I was appointed to the faculty.

Dr. Towers helped make the arrangements for groups of medical students to come to our house for evening rap sessions — quite apart from our formal class meetings. My wife, Ellen, relished the opportunity to give the young people a nourishing meal instead of the hurried sandwiches or hamburgers that often comprised their evening fare.

At the house meetings, the emphasis in the discussions seemed to be on patient-physician relationships. Some of the students at these informal exchanges seemed dubious about the need of the physician to take psychological factors into account in a strategy of treatment. If a bacillus was identified in a workup, they tended to believe that the way of dealing with it was clear and unambiguous: Prescribe the right antibiotic. They lived in a new world of technology designed to provide exact answers. The technology spewed out neat little numbers that all fitted together. The study of anatomy or physiology or biochemistry provided precise descriptions. Everything had a name and everything was in place.

References to the need for a patient-physician partnership, or to the communication skills of the doctor, or to medical ethics, or to the philosophy of medicine or even to the history of medicine, were regarded by some of the students as "soft," and therefore not really primary in medical education. By contrast, subjects such as physics, biochemistry, pharmacology, anatomy, etc. won the favored adjective "hard."

The reasons were not obscure. "Soft" subjects lacked precise answers. The grade-conscious student, therefore, could never be sure that the answers on examination papers would correspond to the professor's judgment. With the "hard" subjects, however, the correct number or fact was certain to lead to a predictable grade. The students therefore tended to steer away from the "soft," just as they gravitated to the "hard."

I was troubled by these habits of thought, for they had unfortunate lines of connection to the world beyond the medical school where uncertainties and not precise answers lay in wait at every turn and where variables characterized most of the equations. Diseases were classifiable, to be sure, but most of the patients who had them were not. In the outside world, a surprisingly large part of the factual base in medicine was vulnerable to new findings and theories. But the physician's style and ability to motivate or inspire patients remained constant. In the years after medical school, much of what had been regarded as "hard" turned out to be frail or faulty, and much of what had been regarded as "soft" turned out to be durable and essential.

In these evening rap sessions, I tried to express the view that medical education should produce well-rounded human beings, interested in people and not just in microorganisms, physicians who could comprehend the reality of suffering and not just its symptoms, and whose prescription

pads didn't exclude the human touch.

Even as I stressed these issues, I realized that the admissions committees of many medical schools had a tendency to use yardsticks that emphasized contrasting qualities. I could understand the reasons. There were at least 20 applicants for every opening. Inevitably, this made grades the most tangible measure on which the school could base its admission decisions. Unfortunately, the emphasis on grades had the effect of making students fiercely competitive. They tended to become barracudas, chewing up on each other, knowing the only way they could rise to the upper half of the class was if someone else was in the lower half of the class. The end product was not necessarily good scholarship but more often a sharpening of academic predatory skills.

Years before they filed their applications to medical schools, students would find themselves veering in the direction of numbers. They had little time to think about the world or to assess and pursue their other potentialities. They had time only to demonstrate their academic abilities, time to pursue the habits of grade-grubbing that would get them into and through medical school. This would not necessarily make them good doctors, nor would it put the emphasis on compassion, sensitivity and respect for life as essential qualities in health-care professionals.

I refer to the situation as it was in the late '70s and early '80s. Since then, medical schools have become increasingly conscious of the importance of the humanities and the liberal arts. However, too many medical students still place excessive value on numbers and grades. Emphasis on grades is apt to lead to the continued pursuit of high numbers in different forms: a better address in front of which to hang their shingles, or a specialized practice beyond the economic capacity of many of the people who most need their expertise.

If people are content to be treated by technologists, there is no reason to be concerned. But if what we want are physicians who understand the individuality of illness, who help patients to develop their own resources in combatting illness, who assess all the intangibles and imponderables that affect the full functioning of a human being, then we may want to give our support to those leaders of medical education who want to broaden medical education. One such leader is Dr. Joel Elkes, Professor Emeritus at John Hopkins University and currently Professor of Psychiatry and Director of Behavioral Medicine at the University of Louisville, who has initiated programs to teach medical students how to maintain their humanity in the face of a mechanistic society.

The gender shift may well be the most striking new development in American medical education.

It is a serious error to suppose that either admissions policy or curriculum policy are fashioned entirely outside the arena of public consensus and consent. If medical school officials are encouraged by the public to search actively for the young men and women who are capable of bringing a certain artistry to the science of medicine, then the stage may be set for wide reforms and great benefits.

When I think of major changes that have occurred during the past 10 years, the first thing that comes to mind is the impressively large number of medical students of both sexes who intend to serve on medical missions in Third World countries. When the students just began to come to the house for dinner and rap sessions, most of them would speak of their intention to go into specialized branches of medicine. By the end of the decade of the '80s, medical service in Africa, Asia or Latin America had an increasing gravitational pull.

An equally significant change since 1980 is the steady increase in the number of women going into medicine. In 1978, women represented about 25% of the enrollment. Ten years later they account for more than 40%, and there are indications that, within another decade, they may be in the majority.

What is true at UCLA is also true of medical schools throughout the country. The gender shift may well be the most striking new development in American medical education. The single greatest consequence of this change is an increase in the number of doctors going into general practice. For almost half a century, the trend has been to specialization, the advantages of which are represented by the availability of highly skilled physicians in dealing with intricate problems concerned with disease and disability. The disadvantages are represented by an inevitable increase in the distance between the patient and the primary physician; an increase, too, in the depersonalization that can distort the patient-physician relationship. Nor must we overlook

the vast increase in medical costs that has accompanied the advent of high specialization. What a half-century ago appeared to be a salutary development in medicine — the availability of honed expertise for elusive medical problems — in time has become a series of overspecialized arenas that departed from the Hippocratic philosophy of an integrated approach to the patient. A patient who is shuttled from one medical office to another, encountering highly sophisticated technology along the way, is likely to be the recipient of a more accurate diagnosis than otherwise, but he may not be the beneficiary of an environment ideally conducive to treatment or healing.

Plainly, the trend to medical specialization has gone too far. Plainly, too, the effect of a substantial increase of women in the medical profession may well be to create a better balance between specialization and primary care. The qualities that tend to be crowded out by over-specialization — greater attention to communication needs, awareness of the importance of reassurance, increased emphasis on the need to understand the circumstances of a patient's life and not just his symptoms — I like to think that these qualities will become primary again with the increase of women in medicine.

True, I have seen no studies showing that women make more compassionate doctors than men, or that they pay more attention to communication skills than men, or that they are more adept at reassuring patients than their male colleagues, but it has been established that the best patient-physician relationships are between patients and general practitioners, whose ranks are now being swelled by women. A far lower percentage of primary care doctors is involved in malpractice suits than any other branch of medicine. The reason is that people are not inclined to sue someone with whom they have a close or established relationship.

In any case, the women among the medical students whom I have met at seminars or house meetings volunteered the opinion — not generally contradicted by the male students — that they may be more adept in meeting the nurturing requirements of patients than their male colleagues.

To the extent that these differences may be true, it is also likely that the related effects may involve lower medical costs. Since specialization and high technology go together, and since the combination of the two can be expensive, any trend in the opposite direction will probably bring down the costs of medical care. This is hypothetical, of course, and it will be interesting to see if such is actually the case as more and more women go into practice.

One would expect that the fact that a higher percentage of women than men intended to go into general practice would also be reflected in a higher regard by women for the so-called "soft" subjects — medical ethics and the medical humanities, for example. Yet the concern over grades was equally distributed over both groups.

I brooded over the tendency of the group as a whole to downgrade the very factors that were basic to effective medical practice, then hit on what I hoped would be a way of persuading them that the "soft" subjects were perhaps even more vital to a successful medical career than the subjects that lent themselves to quantification or precise answers, and thus, to good grades.

Most medical students intend to go into medical practice rather than research or teaching. They would therefore be competing for patients at a time when all the signs indicated a future surplus of physicians. Why not develop "hard" information about the way people choose doctors? What were the traits or style of practice that are highly valued by patients? Did patients search out the most knowledgeable doctors or did they take knowledge for granted and look for other qualities?

The residential neighborhood surrounding the UCLA campus is what the demographers call "upscale." In terms of education, occupation, and economic status, the people in this neighborhood fit the optimum profile of desirable patients. A survey of residents in this area was decided upon and a mailbox questionnaire was drawn up. In general, two major questions were asked:

1.) Have you changed your physician in the past five years, or are you thinking of changing now?

2.) If you have changed physicians or are thinking of changing now, what are your main reasons for doing so?

Fifteen hundred of these questionnaires were distributed and produced a 70% response. Obviously, the ability of the people in this neighborhood to pay medical fees would not be regarded as a disadvantage by students intending to go into private practice.

The most startling figure that turned up was that 85% of the respondents reported that they had either changed physicians in the past five years or were thinking of changing now. Equally startling were the reasons behind the change. When these reasons were tabulated, we discovered that people took knowledge for granted; that was what a medical diploma signified. Beyond that diploma, however, were other factors that counted heavily with patients. The questionnaire

continued on page 572

Ethics — What Is and What Ought To Be

Medical ethics has emerged primarily from a mix of Judeo-Christian precepts, the teachings of moral philosophers and the heritage of the Hippocratic School. The blend has been so thorough that it is often impossible to distinguish the primary courses of specific principles.

Nonetheless, Western medical culture lives by the words of the Father of Medicine, Hippocrates. Sometime between entering medical school and graduation, every student becomes familiar with the oath of Hippocrates. The first portion of the oath lays out the ground rules of a professional society — a willingness to share knowledge with one another and to teach succeeding generations. The second part consists of ethical doctrines. The oath extracts a promise "with purity and with holiness I will pass my life and practice my art."

From the time I left medical school, ethics was assumed by all active in the profession until the 1980s, when a combination of new diseases, high technology and a cry for cost containment created many ethical dilemmas. In 1955 Elmer Hess, then President of the AMA, held a commonly simplistic view of medical ethics. "If a man is good in his heart, then he is an ethical member of any group in society. If he is bad as his heart, he is an unethical member. To me, the ethics of medical practice is as simple as that." Contrast that statement with one by Lois and Michael E. DeBakey in an article written for a medical journal in 1983, titled "The Ethics and Economics of High Technology Medicine." "The exceptional advances of modern medicine have restored to productive life many patients with previously fatal or disabling diseases, but yet these very successes have raised a host of troubling ethical and economic questions. Reconciling society's increasing demands on medicine with the realities of inflation, governmental regulations, changing social values and an aging population poses knotty problems."

In 1987 Daniel Callahan, director and co-founder of the Hastings Center, an institute nationally renowned for its work in the field of medical ethics, wrote a book, "Setting Limits." This book sparked wide debate and was considered blasphemy by some and a blessing by others. Callahan's book will probably never be a best-seller, but it has served the author's intent well as it has marked the beginning of what will no doubt be a long-term discussion. With all of the above in mind and as I'm keenly aware of a multiplicity of contemporary issues with ethical implications, I feel it is timely for the OSMA to

By William J. Marshall, MD
President of the OSMA

begin to explore proactively this subject. To that end I have asked the standing committee on Judicial and Professional Relations, chaired by William H. Kose, MD, to begin this study. Hopefully, as the committee matures in its deliberations, guidelines may be offered to our members.

It would seem subjects for the committee's purview are legion. There are ethical issues that have gained some attention in Ohio. I would hope the committee will briefly review all ethical issues but maintain a focus on those drawing attention in our state. We need to exhibit ethical activism in the areas of self-referral, joint venturing, utilization of limited resources, relationships with industry (i.e., pharmaceutical), and identifying impaired or unethical physicians. This list is not meant to be confining or all inclusive.

The challenge is ours. Our patients are completely dependent on us in ways that buyers are not usually dependent on sellers. All professions are grappling with the ethical dimensions of their professional lives. Because our profession is more visible than most others, the moral scrutiny will continue to be intense.

All of these thoughts bring me back to one of the fundamental tenets in medicine, the doctor as the patient's advocate and the doctor-patient relationship. Warfield T. Longcope wrote in 1932 in the Bulletin of the Johns Hopkins Hospital, "The relationship between the doctor and patient partakes of a peculiar intimacy. It presupposes on the part of the physician not only knowledge of his fellow men but sympathy. This aspect of the practice of medicine has been designated the art; yet I wonder whether it should not, most properly, be called the essence." **OSMA**

American Medical Association Principles of Medical Ethics Preamble:

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall deal honestly with patients and colleagues and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, of colleagues and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate and the environment in which to provide medical services.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

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We are currently seeking a Vascular Lab Technologist. Preference will be given to registered RVT with experience performing carotid, duplex exams, penile impotency testing, peripheral venous imaging and peripheral arterial evaluations. Will consider hospital trained technician.

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Finding Better Ways To Serve

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An Open Letter to the Physicians of Ohio

Barbara Marshall
OSMA Auxiliary President

Dear Doctor:

Does your spouse belong to the OSMA Auxiliary? If so, congratulations on being part of the medical family's championship team. If not, please give me a few minutes to tell you why I think membership would be beneficial to your spouse and your profession.

Medical families are subject to stresses unique to the profession, and only the spouse of another physician can completely understand those stresses. As an organization made up entirely of physicians' spouses, the OSMA Auxiliary and its members serve as a support system for physicians and their families. The OSMA Auxiliary offers an opportunity for your spouse's personal growth and development through seminars and programs on a variety of topics. By utilizing the AMA Auxiliary's Professional Skills Development, your spouse may build a resume useful in the job market by attending instructional courses and training programs.

Membership would be beneficial to you and the medical profession. Working in partnership, the OSMA Auxiliary promotes the programs, priorities and goals of the OSMA. Our members enhance the positive image of medicine with volunteer service designed to meet the needs of our individual communities. Projects include health fairs, Mobile Meals, shelters for abused women and education on tobacco products, substance abuse and adolescent health.

Doctor, you know first hand that health-care issues are decided not in your office or at the hospital, but in the Statehouse and Congress by legislators who have never treated a patient. The OSMA Auxiliary has proven itself to be one of medicine's strongest voices. Through our long sponsorship of the annual "Day at the Legislature," we have provided an opportunity for hundreds of auxilians and physicians to become

_____ Yes, I would like to join the Ohio State Medical Association Auxiliary

Name _____

Address _____

City/State/Zip _____

Telephone _____ County _____

_____ OSMA Auxiliary $12

_____ OSMA Auxiliary and AMA Auxiliary $32

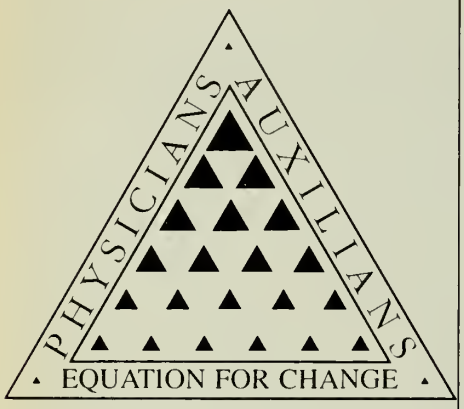
For spouses of resident physicians and medical students:

_____ OSMA Auxiliary $2

_____ OSMA Auxiliary and AMA Auxiliary $9.50

Please make your check payable to OSMA Auxiliary and mail to:

OSMA Auxiliary
1500 Lake Shore Drive
Columbus, Ohio 43204-3824



acquainted with their elected representatives and informed of the issues. Our members have lobbied to enact sound legislation. Phone banks throughout the state enable us to generate hundreds of contacts to legislators on very short notice to express medicine's views.

As the cost of medical education escalates, the OSMA Auxiliary continues its long support of AMA-ERF to provide grants to medical schools for educational programs and financial assistance to students. This year OSMA Auxiliary raised $60,000. Nationally, $49 million has been raised and distributed by AMA-ERF since its inception in 1951.

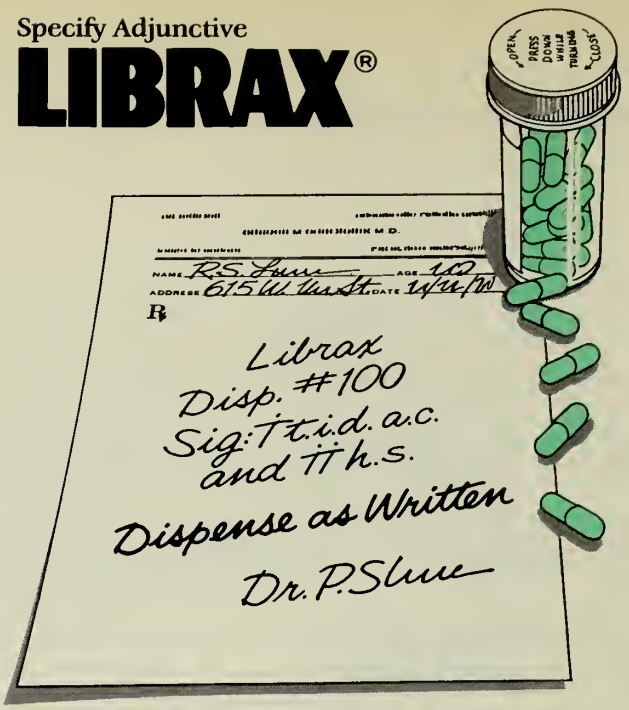
The spouse of every physician and medical student in Ohio is eligible to join the OSMA Auxiliary. If you live in a county without an organized Auxiliary, your spouse may become an at-large member and receive all the publications and benefits of membership.

I urge you, Doctor, to discuss membership with your spouse. We extend an open invitation to join an organization whose goal is to protect and improve public health and to assist physicians in providing quality medical care.

Barbara Marshall
OSMA Auxiliary President

Specify Adjunctive

LIBRAX®



Each capsule contains 5 mg chlordiazepoxide HCL and 2.5 mg clidinium bromide.

Please consult complete prescribing information, a summary of which follows:

* Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).
Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.
As with all anticholinergics, inhibition of lactation may occur.
Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).
Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.
Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.
Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

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OH

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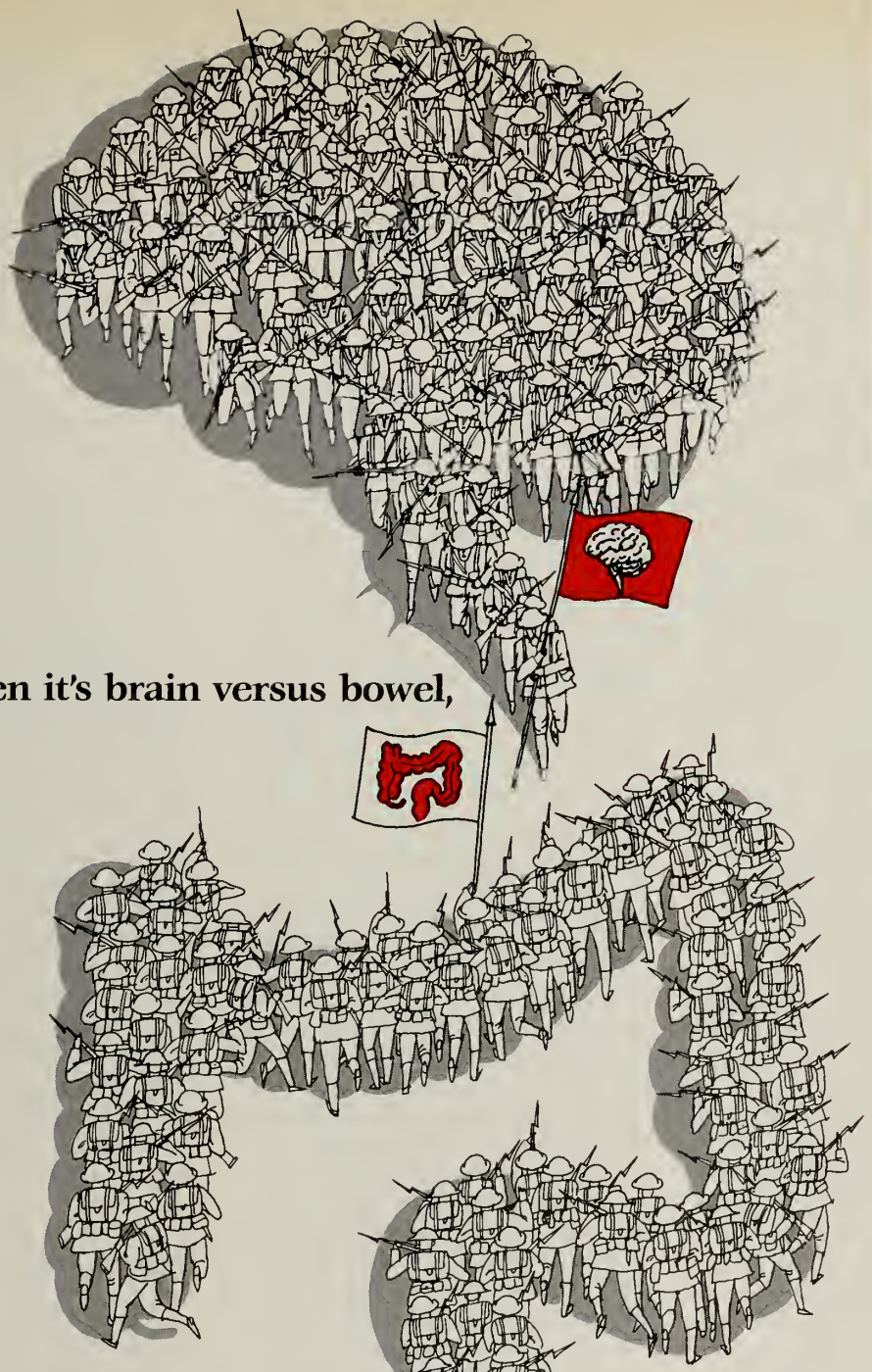

In IBS,* when it's brain versus bowel,

IT'S TIME FOR THE PEACEMAKER.

In irritable bowel syndrome,* intestinal discomfort will often erupt in tandem with anxiety—launching a cycle of brain/bowel conflict. Make peace with Librax. Because of possible CNS effects, caution patients about activities requiring complete mental alertness.

*Librax has been evaluated as possibly effective as adjunctive therapy in the treatment of peptic ulcer and IBS.

Specify Adjunctive

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Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide.

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Please see summary of prescribing information on adjacent page.

LETTERS TO THE EDITOR

Generic vs. brand name: a case history

To the Editor:

I am writing to you to share my experiences with generic Desipramine and its effects on three patients, all of whom are classified as Bipolar Affective Disorders.

The first patient is a 65-year-old female who had classical depressive symptoms with neurovegetative dysfunction. She was hospitalized many times in the past by different psychiatrists and had shown a positive response to brand name Norpramine. During her hospital stay, she responded with brand name Norpramine and her depressive symptoms subsided. When she was seen post-hospital as an outpatient, she had a recurrence of her depressive symptoms with a lot of anxiety, a feeling of flu-like symptoms and a sense of helplessness. Since this patient had responded to Norpramine in the hospital, blood levels were ordered. Desipramine levels ranged in the region of 803 nanograms per milliliter and within a week it was still in the high range of 457. About a week later, it was 348. It took almost six weeks for it to come down to therapeutic ranges. When this patient was switched to brand name Norpramine and again the blood levels were monitored, she showed improvement and did not have the adverse effects of high levels of Desipramine. This case showed a clear demonstration of the generic Desipramine vs. the brand name Norpramine and the bood levels that fluctuate to such high degrees, even on less than therapeutic doses such as 150 milligrams of Desipramine a day.

The second case is a 29-year-old female nurse who was treated successfully for a manic episode with Lithium Carbonate, 900 milligrams a day, in April of 1988. Once her manic episode was controlled, the patient became noncompliant with the Lithium and had to be rehospitalized on August 4, 1988, presenting with depressive symptoms. In the hospital, she was started on brand name Norpramine in a dose of 150 milligrams a day. There were no adverse effects and her depressive symptoms subsided. She was discharged and was seen in the office three weeks later, still on the same schedule of Norpramine. On September 21, 1988, which would be about three weeks after the first office visit, she began to show dysphoric symptoms. By that time, she had filled the prescription with Desipramine (Goldline Labs) and had been taking the same schedule of 150 milligrams a day. Again, since her symptoms of depression presented itself with the same schedule of Desipramine, blood levels were drawn. The blood level was 493 nanograms per milliliter, accompanied by the flu-like symptoms and agitation. The generic Desipramine was discontinued and the brand name Norpramine was substituted and blood levels were monitored. She responded to the brand name Norpramine, 150 milligrams a day. The flu-like symptoms and agitation subsided, the dysphoric symptoms improved, and she was euthymic.

The other case is a 57-year-old Caucasian male with a long history of an Atypical Bipolar Disorder, where his depressive episodes are of long duration. He has been under the care of many psychiatrists and many hospitals. He was hospitalized from March 25, 1988, until April 2, 1988, for depression. At that time he was on Lithium Carbonate, brand name Norpramine and Tegretol. His response was fair, but his symptoms recurred when the patient had been given generic Desipramine substituted by the pharmacist. His symptoms recurred with flu-like symptoms and his blood levels were monitored. They were in the high range with generic Desipramine and later, when he was switched to the brand name Norpramine, he responded to normal doses.

In summary, I have become more aware that generic Desipramine has wide fluctuation in the blood levels, mostly in toxic ranges, even with normal therapeutic doses. These adverse effects were reported to the pharmaceutical company of Merrell Dow and case histories were given over to their medical department. If you need any further information regarding these cases, please feel free to call.

Clifford C. Perera, MD
Cuyahoga Falls
Board-certified Psychiatrist
Associate Clinical Professor
Northeast Ohio University
College of Medicine

Snitches and the law

To the Editor:

As a member of the Ohio State Medical Association, I receive *OHIO Medicine.* In reviewing your article entitled "The Ohio State Medical Board: Is It Doing Its Job?" which appears in the May 1989 edition, I noted one area on which there should have been substantial elaboration.

The "snitch law" (Sec. 4731.224 of the Ohio Revised Code) was quoted in its entirety. There was, however, a failure to set forth the provisions of Section 4731.99 which sets forth the penalties for violating said "snitch law." That section reads, in its pertinent part, as follows:

(E) Whoever violates division (A), (B), (C), or (D) of section

4731.224 (4731.22.4) of the Revised Code is guilty of a minor misdemeanor on a first offense; on each subsequent offense the person is guilty of a misdemeanor of the fourth degree, except that an individual guilty of a subsequent offense shall not be subject to imprisonment, but to a fine alone of up to $1,000 for each offense.

One who fails to "snitch" is thus guilty of a misdemeanor in the fourth degree. As such misdemeanor was committed in the course of the physician's practice, it, in itself, is a cause for discipline by the Ohio State Medical Board pursuant to the provisions of section 4731.22 of the Ohio Revised Code.

In summary, a failure to "snitch" not only subjects one to a monetary penalty but, also, to the imposition of sanctions by the Ohio State Medical Board.

Frank C. Woodside, III, MD, JD
Cincinnati

To the Editor:

"Snitch — betrayer, tattler, blab, squealer" — Roget. Is "snitch" an appropriate word to describe a member of our profession who acts on our "firm stand on the ethical obligation to expose . . . unethical conduct on the part of its members" — Clarke. Or does it better characterize the accusation that we "foster a medical conspiracy of silence"?

Does *OHIO Medicine* (May '89, p. 365) inadvertently undermine doctors trying to decide whether to report an unethical colleague by referring to that action as "snitching"? However conventional that description of our obligation, I suggest we abandon our double message. Ethical behavior is hard enough without it.

Karl W. Hess, MD
Cleveland

Billing confusion

To the Editor:
(RE: Dr. Baumgartner's "Presidential Perspectives")

Your article on "Billing Confusion" in the April 1989 issue of *OHIO Medicine* has come to my attention. Let me congratulate you on your perceptive analysis of the complexities of medical billing.

Those of us who have experienced the "billing confusion" have pleaded for simpler procedures. I have heard the horror stories over and over again, and you describe them well; but responses for addressing the problem have been all too slow in coming.

As President of the Ohio State Medical Association, your proposal is especially refreshing:

- to reduce the complexity of the present billing system;
- to appoint a committee of the OSMA Council to review the system and recommend simpler procedures;
- to program computers and instruct billing agents to include "user friendly" information and explanatory statements;
- and above all, to establish services in hospitals or physicians' offices to assist in filling out forms, filing them and tracking them through the system.

Perhaps you have seen the May 1989 issue of *Health Care Financial Management.* An article titled "Focus Groups Improve Billing Practices, Patient Relations" offers several good recommendations.

When even those of us who are healthy and college educated find the process confusing, it is long past time to provide assistance to the elderly who are recovering from illness, with its emotional and psychological strains, only to be confronted by a maze of incomprehensible paper processing.

There is always the concern that if the federal government finds it necessary to intervene and mandate procedures, it may do so with a heavy hand. I cannot emphasize enough, therefore, how much better the process could be if the medical community could indeed provide a simpler, "kinder and gentler" form of medical billing.

I commend you for the proposal and hope you will encourage its implementation.

Howard M. Metzenbaum
United States Senator

Therapeutic effects of prayer

To the Editor:

We are involved in a study of the therapeutic effects of intercessory prayer and are interested in hearing from anyone who has conducted such work. If you have carried out such a study but have never published the results, could you please contact us? If you have not personally been involved in such a study but know people who have, would you please share their names and addresses with us? Thank you for your cooperation.

Sincerely,

Michael Zimmerman
Professor of Biology
Oberlin College
Oberlin, Ohio 44074
(216) 775-8517
(216) 775-8315

Jeffrey A. Witmer
Assistant Professor of Mathematics
Oberlin College
Oberlin, Ohio 44074
(216) 775-8381
(216) 775-8380

OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians

Medical schools to tap liberal arts pool

In years past, students who applied for medical school came largely from a pre-med background or one rich in the study of the biological sciences. Now that medical school admissions are down, however (enrollment in U.S. medical schools has fallen in each of the past six years), more and more medical schools are turning to other groups to fill their vacancies.

Recently, in fact, the Association of American Medical Colleges announced that the basic admission test to medical school will balance the traditional focus on science with a new section that will evaluate the applicant's thinking and writing skills.

"This is a major message to English and history students and others who have been afraid of medical schools in the past," says Richard Behrman, dean of the School of Medicine at Case Western Reserve University in Cleveland, in an article that appeared in the *Washington Post.* "We want you and we need you. This is no longer a world in which a doctor can afford to be a narrow, poorly educated human being," he continues.

Medical school officals have expressed dismay over the low reading scores and verbal skills of candidates.

"The current test has proved very good at predicting how a student will perform in medical school," says Richard L. O'Brien, dean of the Creighton University School of Medicine and chairman of the AAMC committee that devised the new exam, also in the same article. "But it has not always brought the range of applicants we seek. We believe that this new MCAT (Medical College Admission Test) will be more responsive to the changing realities of medical practice in America."

The current admission test has six sections — biology, chemistry, physics, scientific problems, reading skills analysis and quantitative skills analysis. The new exam, which will be introduced in 1991, will have four sections — biological sciences, physical sciences, verbal reasoning and a writing sample.

Depression now strikes at younger age

Depression, usually the malaise of middle-aged women, is now affecting more and more adolescents, say the authors of a study recently published in the *Journal of the American Medical Association.*

According to the report, young people, ages 15 to 40, in North America and Europe were twice as likely to show depression in the 1960s and 1970s as they were before World War II.

"Depression seems to be the price of civilization," says one of the study's researchers, Gerald Klerman of Cornell University Medical School. "We're always making or breaking attachment bonds. We give up some of the social supports and stable relationships."

He continues: "It's sort of a paradox that the Baby Boom generation, physically, is the healthiest generation in history, and grew up in a time of great economic prosperity, and yet they have this sense of malaise and disappointment."

The economic prosperity Dr. Klerman alludes to, however, could be responsible for the increasing rates of depression and suicide among youth, speculates Mark Walker of the adolescent psychiatry program at Northwestern Memorial Hospital.

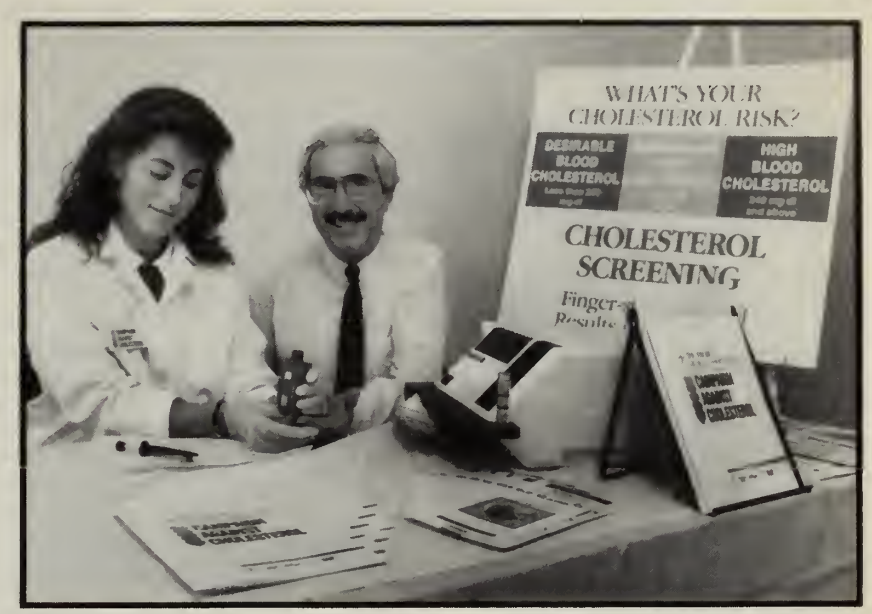
"Young people lack a certain degree of meaning in their lives," he says. "That is a result of an increasingly affluent society able to support people having a longer adolescence when they do not have to work to survive."

Birth control options may increase

While the birth control pill still remains the method of choice for most couples planning families, there are other, promising contraceptive alternatives that may soon find their way into the American marketplace.

Here are a few of the ones your patients may be learning about — and asking you about — in the near future.

- Implants — implantable pellet, inserted in a woman's upper arm. The pellet releases progestin into the bloodstream for up to five years, and would have to be pulled out if the woman wished to stop using it.
- The male pill — although versions are being tested, researchers admit that it is easier to stop one egg than several million sperm. While the so-called "male pill" can effectively reduce sperm count by 95%, that may not be good enough to prevent pregnancy. Some versions also seem to depress libido.
- RU-486 — an anti-progesterone product that prevents implantation of the fertilized embryo in the uterus. Abortion opponents are fighting the introduction of this product into the country.
- Injections — a shot of progestin that would prevent conception for three to six months.
- Vaccines — in the testing stage. The problem seems to be finding a vaccine that works in the short-term, and which can be successfully reversed at a later date.
- Vaginal pill — a tablet that slowly releases spermicide for up to 24 hours.
- Vaginal ring — a ring, fitted around the cervix, that would release progestins for three to four months. Another version releases both progestin and estrogen for three weeks each month, then is removed during menstruation.



The AMA's Cholesterol Campaign

The American Medical Association has a problem with cholesterol. The problem is that high blood cholesterol is associated with the development of coronary heart disease.

Half of all adult Americans are estimated to have blood cholesterol levels of 200 mg/dl or higher — a level considered "high risk" by the National Heart, Lung and Blood Institute. To help combat this risk, earlier this year the AMA initiated its "Campaign Against Cholesterol." Included in the AMA's artillery: a nationwide course on cholesterol reduction, national and syndicated TV specials, a continuing education program for physicians and an AMA official cholesterol reduction book.

"The key weapon in the AMA's Campaign Against Cholesterol is information," explains James H. Sammons, MD, AMA Executive Vice President. "We have the ability to control this problem, but first we must educate the public about the risks of high blood cholesterol and the methods available for treating it."

As part of the campaign, physicians are being asked to screen patients for high blood cholesterol. Screenings will also be conducted in shopping malls, supermarkets and pharmacies across the country.

For those individuals determined to have high blood cholesterol, the AMA has developed a five-week cholesterol reduction course emphasizing dietary therapy and positive lifestyle changes. Most participants are expected to be referred by their physicians, but the course is also open to the general public.

The courses will be offered in cooperation with local health organizations in selected cities. The AMA eventually hopes to expand the program nationwide.

The AMA has also made available an official book on cholesterol reduction, "Count Out Cholesterol," by Arthur Ulene, MD, of NBC's "Today Show." "We are publishing this book to ensure that the public has a safe and scientifically sound program for cholesterol reductions," says Dr. Sammons.

Copies of the book are available by writing: Shelley Kern, Feeling Fine Programs, Inc., 3575 Cahuenga Blvd. West, Suite 440, Los Angeles, CA 90068 or by calling (213) 851-1027. The cost for physicians is $15 per book plus $3 shipping and handling.

COLLEAGUES

ROBERT GRAY, MD, Prospect, has been named Republican of the Year by Marion County's Republican Club . . . **THOMAS TODD, MD, ELMER WAHL, MD,** and **BARRY WEBB, MD,** all of Cincinnati, have received awards of distinction for contributing to the education of medical students at the University of Cincinnati . . . **JACOB W.E. DIJKSTRA, MD,** Cleveland, has been named to Cleveland Heights High School's Alumni Hall of Fame . . . **RAY W. GIFFORD, MD,** Cleveland, has been appointed to the board of commissioners of the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) . . . **STEPHEN H. POWELL, MD,** Cleveland, has been named medical director of Heather Hill nursing home . . . **DAVID EFFRON, MD,** Cleveland, will serve as ship director for three weeks this summer on the *Sea Cloud,* the world's largest passenger ship . . . **SEAN R. CONVERY, MD,** Dayton, has been named a Dayton area "Up and Comer," an award honoring outstanding business and community

Henry Krueger, MD

leaders under the age of 40 . . . Fairview General Hospital recently toasted several physicians for their long-standing service to the hospital. They are: **HENRY KRUEGER, MD,** North Olmsted; **WILBERT THOMAY, MD,** Cleveland; **GEORGE LEICHT, MD,** North Olmsted; and **MARVIN SHIE, JR., MD,** Cleveland . . . **BAHMAN CUYURON, MD,** Lyndhurst, has received the Greater Cleveland Health Professional of the Year Award . . . **JOHN R. SCHARF, MD,** Dayton, has been named chief of staff at St. Elizabeth Medical Center . . . **DAVID F. MITCHELL, MD,** Dayton, has been appointed director for the Muscular Dystrophy Association's clinic at St. Elizabeth Medical Center . . . **ROBERT L. CROSS, MD,** Martins Ferry, has received a three-year appointment as Cancer Liaison Physician for the cancer program at East Ohio Regional Hospital . . . **ELLIOT DICKMAN, MD,** Cleveland, has been honored with a Medical Achievement Award by Camp Simcha, a summer retreat for Jewish children with cancer and other life-threatening diseases . . . **RICHARD T. BURKHARDT, MD,** Hamilton, has been elected president of the medical staff at Mercy Hospital . . . **ALAN ANGEL, MD,** Highland Heights, has been named chief of staff-elect of Meridia Euclid Hospital . . . **GERALD MARSA, MD,** Sylvania, has been named chief of staff at Flower Memorial Hospital . . . *Good Housekeeping* magazine has named **BARTH HOOGSTRATEN, MD,** and **BERNARD S. ARON, MD,** both of Cincinnati, as two of the country's 184 most outstanding physicians in the treatment of breast cancer . . . **ROY BONTRAGER, MD,** Logan, has been inducted into the Alpha Omega Alpha Medical Honorary society by the Gamma Chapter at Ohio State University . . . **JAMES BAZZOLI, MD,** Marion, has received a Distinguished Service Award from the AMA National Congress on Adolescent Health . . . **CHRISTOPHER MEIER, MD,** Fairfield, has been elected chief of staff and chairman of the Medical Executive Committee at Mercy Hospital . . . **RANDALL G. THARP, MD,** Andover, has been elected 1988 president of the American Osteopathic Academy of Sports Medicine, the largest physician sports medicine society in the country . . . **TIMOTHY L. STEPHENS, MD,** Cleveland, has been named president of the medical staff at St. Luke's Hospital . . . **PAUL MATTHEWS, MD,** Fremont, has received a three-year appointment as Cancer Liaison Physician for the cancer program at Memorial Hospital . . . Four Butler County physicians were honored for contributing to the medical education of students at the University of Cincinnati. They are: **RICHARD BURKHARDT, MD,** Hamilton; **JAMES SIMCOE, MD, MICHAEL BARBER, MD,** and **CHRISTOPHER MEIER, MD,** all of Fairfield.

GUILLERMO ALFONSO, MD, Akron, has been appointed chief of surgery at St. Thomas Hospital . . . **OTTO STEINREICH, MD,** Akron, has been honored by the Summit County Medical Society for 50 years of medical service . . . **WOONG SUH KIM, MD,** Bowling Green, has received an outreach service

Ray W. Gifford, Jr., MD

award from the International Institute of Greater Toledo, Inc. Dr. Kim was one of the founders and past president of the Korean American Association of Northwest Ohio . . . **KATHERINE M. HOTT, MD,** Dayton, has been named medical director of Behavioral Health Services at Middletown Regional Hospital . . . **BERYL R. FRUTH, MD,** a Columbus family practitioner, has been named to "Who's Who of American Women" . . . **E. MITCHEL OPREMCAK,** has joined The Ohio State University's Department of Ophthalmology as director of ocular research . . . **ARMAND MANDEL, MD,** Cleveland, has been elected president of the medical staff at Parma Community General Hospital . . . **JOEL M. SALON, MD,** has been elected president of the Northeast Ohio Society of Oral and Maxillofacial Surgeons for 1989 . . . **JOSEPH P. GOLDBERG, MD,** Painesville, has been named assistant medical director of the Ohio Permanente Medical Group, Inc. . . . **MARK H. FEINGOLD, MD,** Willoughby, has been named the group's physician-in-chief . . . **JOSEPH BURNS, MD,** Warren, has been elected president of the medical staff at Trumbull Memorial Hospital . . . **HENRY SHORR, MD,** Youngstown, has been elected president of St. Elizabeth Hospital Medical Center's medical staff.

OHIO MEDI-SCENE

The State Science Day competition . . . 1989 future scientists . . . CME programs . . . reporting live from the OMPAC Luncheon . . . 1989 OMPAC awards . . .

. . . And who will inherit our legacy?

What causes muscles to contract? What is caffeine's effect on bodily reactions? How does exercise affect the heart?

If you think these questions are the latest to be circulating around the medical research labs — think again. The above queries — and literally hundreds of others — were recently posed, and answered, by adolescents. That's right. The same age group who, according to recent news reports, have no interest in, and very little knowledge of, the physical sciences.

To a large extent, the news reports are right. Students seem to be spurning science as a career choice these days — and all the science professions, including health, are suffering as a result.

"That's why it's important for physicians to take time to encourage a student's interest in science," says Richard G. Orlando, MD, of Dublin.

Dr. Orlando was one of 12 OSMA members from around the state who recently gave up a beautiful spring Saturday to travel to the Ohio Wesleyan University campus in Delaware, where the 1989 State Science Day Competition for junior high and high school students was being judged. Each year, the OSMA honors the best medical exhibit of the competition, and Dr. Orlando was among those who would decide this year's winner.

In addition to his responsibilities as judge, Dr. Orlando was also serving as one of the representatives from the OSMA's Young Physicians Section, a group that enthusiastically supports such academic encouragement — both at the state and national level.

"Enrollment in all the health sciences is down — not just in medical school, but in nursing and medical technology as well," Dr. Orlando continues. "We need to stimulate an interest in the sciences, and I think we can do so by emphasizing that science can be fun."

A quick look around the cavernous Branch Rickey Fieldhouse seems to be all the proof anyone needs that science can at least be an endlessly

Congratulations to 1989's Future Scientists:

7th Grade — **Anne E. Hofmann,** Canton, Ohio, Pleasant View School for the Arts "What Causes Muscle Contraction? ATP? ATP+? KCl and MgC12? Adrenaline?"

8th Grade — **Jeremy N. Liegl,** Shaker Heights, Shaker Middle School "The Effects of Exercise on Jet Lag"

9th Grade — **Caryn E. Cooley,** Fayette, Gorham-Fayette High School "The Relationships of Age and Gender on Resting and Exercise ECGs and Heartbeat Rates"

10th Grade — **Todd R. Garcia,** Bowling Green High School "How the Amino Acid Tryptophan Mediates the Effects of UV Light on the DNA Component Guanine"

11th Grade — **Takehisa Ikeda,** Columbus, Northland High School "Can Dietary Fiber Be Beneficial to Health?"

12th Grade Winner **Rolf N. Barth,** Upper Arlington High School, was voted OSMA's top-award winner with his exhibit "Transplantation of Cryogenically Stored Epithelial Tissue." He will be presented with a plaque and a $100 U.S. Savings Bond. The five grade-level winners will receive framed certificates from the OSMA.

OHIO MEDI-SCENE

Our legacy . . . *continued*

fascinating subject. Not all of the exhibits there were medically oriented, of course.

"However, our judges have about 70 exhibits to consider this year," states Bob Clinger, Director of OSMA's Department of Medical Society and Member Relations, who coordinates the judging each year.

And, each year, the number of exhibits competing for OSMA recognition continues to increase, notes Clinger — certainly an encouraging sign. Yet, even more encouraging is the observation made by Judy Westman, MD, of Columbus, another OSMA judge.

"The quality of the exhibits has improved tremendously since I started judging four or five years ago," she says.

She and Dr. Orlando both recall their own attempts in science fair competitions, and admit that today's entrants are at least equal to, if not better than, their own entries were.

"I never made it past the regionals," Dr. Orlando recalls with a laugh.

"We are seeing the best here — the cream of the crop," points out Thomas E. Shaffer, MD, a retired pediatrician, also from Columbus. His specialty, when he was practicing, was adolescents, and he says that's what draws him here, year after year, to serve as judge.

"They all do such a super job — it's remarkable, really. Even down at the seventh-grade level they come up with some excellent projects."

Which, needless to say, makes judging a little difficult.

Just ask Melanie Kennedy, MD, Columbus, who has served as an OSMA judge since 1982. Until this year, she co-chaired the team with James Hickson, MD, of Mt. Gilead. This year, however, she soloed as the team's chairman.

"We have a list of things we look for when judging," she says.

The knowledge of the student, the student's use of scientific method, the clarity of expression, and the originality and creativity used in devising and carrying out the project are all important factors the judges look for.

"I also keep in mind the level of experience and education of the student," she says. "For example, a project may not be too sophisticated for a 12th-grader, but for a seventh-grader, it might be very advanced."

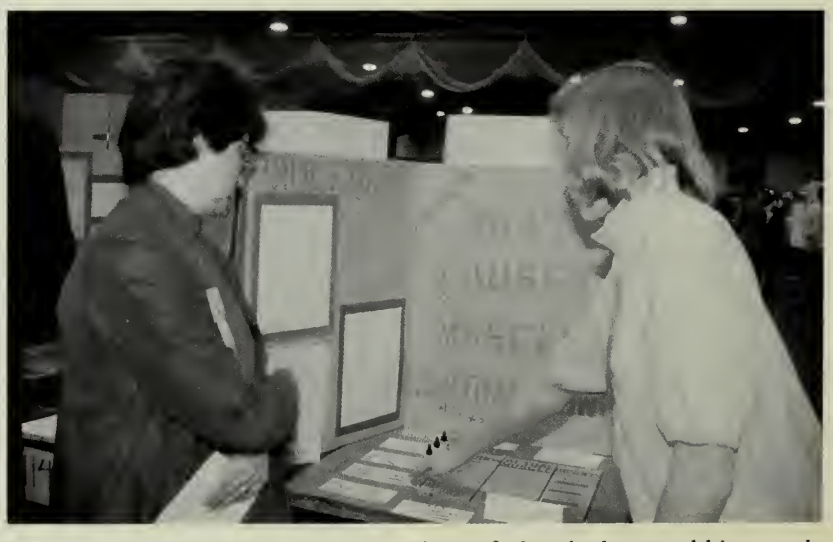
"I look to see what their hypothesis is, and how they tested that hypothesis," says Dr. Westman. "Then I check to see if they learned something from the project — even if their hypothesis didn't work out."

The student's thought process is equally important to Dr. Orlando.

"I want to know how they thought it through . . . did they use good scientific method?"

But while Dr. Shaffer is also interested in the student's original premise, and how he or she acted on the suggestion, he also looks to see how much work the student put into the exhibit.

"I make sure, first, that there hasn't been a lot of adult input into the project — but you'd be surprised how much time these kids put into their exhibits. Some



A seventh-grade student tests a variety of chemicals on rabbit muscle tissue to determine which will cause contractions.

of them have to make daily observations of an experiment they're conducting, for example. It really can be time consuming."

Tagging along with Dr. Kennedy as she judges some of the seventh- and 11th-grade entries prove Dr. Shaffer et al to be correct in their statement that the exhibits are not only time consuming, but, overall, amazing in their quality.

The first stop was at an exhibit by a seventh-grade girl who had placed an assortment of chemicals (ATP, ATP+, KC1 and MgC12, and adrenaline) on a sliver of rabbit muscle to see which, if any, would cause the muscle to contract. Her exhibit was replete with charts, graphs and crystal-clear summations. Her presentation and understanding of her project was flawless.

"Where did you get your idea for the project?" asks Dr. Kennedy.

"My father is a physician, and he helped me kick around a few ideas," she answered. (Which answered for *me* the question of how a seventh-grader knew where to secure a sample of rabbit tissue — a bit of information not generally possessed by the average pre-teen.)

Actually, however, physician offsprings are hardly rare at these shows. Children of at least two OSMA members exhibited projects at this year's state competition, and Dr. Kennedy says her own daughter has entered such science competitions in the past.

"More physicians could provide encouragement to other children as well, by acting as advisers," she notes. High schools and junior high schools are constantly looking for physicians and other scientists to help students on these projects, and volunteering is usually as simple as calling the school principal and indicating your willingness to help.

Dr. Kennedy gave the young lady high marks for her exhibit (in fact, she ended up as the seventh-grade level winner), then scurried off to locate the next entrant on her list.

This student project investigates the question, "Which toothpaste . . . is most abrasive?"

The judges can choose to review their assigned grade-level exhibits in tandem with another team judge, or elect to judge their list solo. According to Clinger: "It depends on how comfortable they are with the judging process. Some of the newer judges, for example, may elect to go around with someone who has been doing this for awhile." However, each entry for OSMA recognition will be judged by at least two OSMA members, sooner or later.

"The main problem we have at these competitions is the time crunch," Clinger continues.

And what a time crunch! (Rather like those days your staff has overbooked your appointments.) The dozen OSMA judges must somehow manage to fairly evaluate over 60 exhibits — twice — and arrive at grade-level winners and one overall winner in a time frame of two to 2½ hours.

"We're usually the last ones here to come up with the name of our winner," Clinger says. (The osteopaths, for example, had no trouble meeting this year's deadline — their six judges had only 10 exhibits to evaluate.)

The OSMA judges, however, reflect the very essence of grace under pressure. They chat easily with the entrants — politely overlooking the fact that some of the younger entrants are so nervous their voices quiver when they speak. Dr. Kennedy giggles appreciatively with the 11th-grade entrant who, in explaining her

The OSMA Science Day Judges

Thanks to the following physicians who served this year as judges for the State Science Day competition:

- **Melanie S. Kennedy, MD,** Columbus, Chairman
- **William T. Collins, MD,** Lima
- **Dennis M. Doody, MD,** Columbus
- **John D. Hubbell, MD,** Lima
- **Susan Hubbell, MD,** Lima
- **John McFadden, MD,** Cuyahoga Falls
- **Mark Mentser, MD,** Columbus
- **Richard G. Orlando, MD,** Dublin
- **Charles B. Reiner, MD,** Delaware
- **Thomas E. Shaffer, MD,** Columbus
- **William G. Wasson, MD,** Canton
- **Judy Westman, MD,** Columbus.

OHIO MEDI-SCENE

Our legacy . . . *continued*

study of which make-up product is best for the skin, says she counted only whiteheads for the project — more commonly known to teen-agers as "zits" — because if she took the time to count all of her blackheads, she never would have had time for anything else.

By and large, however, the students do demonstrate the kind of time commitment Dr. Shaffer has alluded to. (After all, not every teen-age girl is willing to get up at 6:00 every morning to count zits. "I had to perform the study on myself," she told Dr. Kennedy, "because I couldn't ensure that my friends would get up at that hour every day for a month.") One entrant, a seventh-grader who had completed a project on cancer and the throat, actually took time to visit a speech therapist to learn how to speak with a voice adapter.

"It took me three visits to learn to complete a couple of simple sentences," she told Dr. Kennedy.

Despite the time squeeze for the judges, they make their choices wisely. The fact that some of their picks have gone on to international competition probably says more about their decisions than anything else could.

This year's winners are listed in a separate sidebar story. The overall winner was Rolf N. Barth, a 12th-grade student at Upper Arlington High School in Upper Arlington. His exhibit explored the "Transplantation of Cryogenically Stored Epithelial Tissue" — a complicated and sophisticated subject, worthy of any research lab.

"You know," Dr. Shaffer muses, "it would be interesting to track our winners to see what kind of careers they *do* choose . . ."

Clinger reports that's an activity he hopes to accomplish in the near future, but William G. Wasson, MD, of Canton and one of the team of OSMA judges, says he already has some tangible feedback on that issue.

"I'm on the admissions committee at Northeastern University College of Medicine," he says, "and I've started to notice some of the applicants we've been getting at our school have been previous winners here at the science fair."

Encouraging words for a profession that looks to its younger generation to carry on the technical and medical marvels it leaves behind in legacy.

And encouraging words indeed for the dozen dedicated physicians who have given up a beautiful spring Saturday . . . — *Karen S. Edwards*

Are your CME programs as flimsy as the Emperor's new clothes?

If you're in charge of the continuing medical education program at your hospital, medical school or other facility, you may want to take a quick look to see whether or not your programs are like the proverbial "Emperor's clothes."

That's the advice that Charles E. Osborne, Director of the Office of CME at the Children's Hospital National Medical Center in Washington, DC, gave participants in the Ohio Annual CME Workshop, sponsored by OSMA's Committee on Education. The workshop was held this past April in Columbus.

Osborne's offbeat analogy comes from the childhood tale, which revolves around an emperor who was deceived into believing he had just purchased a handsome new set of clothes when, in fact, there was nothing there at all — not even a snippet of thread. No one, of course, chancellor or townsperson, dared to tell the emperor that his fine suit was cut from imaginary fabric, until one day, as the Emperor strolled the streets in his new array, a child pointed to him and said, "But look, he doesn't have anything *on*!"

The illusion was instantly shattered; the "tailors" were exposed as the charlatans they were.

The lesson here, says Osborne, is to learn to be the child when assessing CME programs — and recognize when there is really nothing of any value there.

Whether or not you are then able to effect a change and upgrade your programs depends on several things. For example, what level of commitment does your institution make to CME?

Osborne, like the child in the tale, holds no illusions.

"The natural inclination is to dump CME off onto the lowest-paid person in the place," he says. "Administrators refuse to put money into programs, but they expect a big return on the other side" — largely, he continues, through increased referral patterns that will bring more patients through their doors.

"But it's hard to change referral patterns," Osborne notes, pointing to physicians whose hands are tied by HMO contracts and other factors. So, when patients *don't* come through the doors, administrators are cautious about increasing budgets — especially CME budgets.

Still, Osborne notes, there *are* things you can do to upgrade your programs, if you're careful. He offers the following advice and tips to CME planners:

Travel programs:

• Desirable locations, including programs offered aboard cruise ships, are admittedly a draw. You'll simply be able to get more participants to sign up for a program if it's held in Las Vegas instead of, say, Des Moines, Iowa — "and there is nothing wrong with that, but your concern should be with high quality programs and not junkets," Osborne warns. "The thing that worries me are those slick, colorful brochures you get about a location with the sentence, 'educational program to be announced.' Obviously these planners are not concerned with the program at all."

• "When you are doing a travel program, recognize that when you hire a speaker, you'll be hiring that speaker's family, whether you want to or not." Be aware of any problems that may occur as a result . . . i.e. how will spouses interact with the seminar's participants?

• You can do travel meetings to see how people practice medicine in other countries, says Osborne, who has done several such trips to China, "but don't tell participants they are going to learn how to practice Chinese medicine, or will learn all they'll need to know about Chinese medicine. There isn't enough time."

• If you'll be traveling yourself this year, take a look to see if there will be CME programs offered at that location during the time you will be there. "It's a logical thing to do," he notes. In addition to earning CME credit, you can see how other programs are put together. Also, keep in mind that other physicians are practicing this technique as well, and market your own programs accordingly. "If I could find a way to mail my program to physicians' spouses, I'd do it," he comments (assuming, of course, it's the spouse who selects the vacation site).

• Don't worry about participants being lured by an attractive location's attractions. According to Osborne, there is a hard-core 5% of participants who never attend anything except the opening cocktail reception, "but the majority who sign up for a program generally do attend."

Drug company underwriters:

• There was a time when speakers could be paid a $100 honorarium, but that time is long since past, says Osborne. Speakers with any kind of respectable credentials are now asking (and getting) $500 for in-town programs; $700 for out-of-town programs; and $1,000 or more if an overnight stay is involved. Such fees can soar outside some CME budgets, so drug companies may be brought in to help underwrite the costs. "Drug companies are not bad people," says Osborne, "but they're a lot like kids. They want to see what they can get away with." The trick in dealing with these big-pocket backers is to make sure they don't gain control of your meeting. Don't, for example, let them choose the topic or the speakers — and don't let them pay your speakers directly, he warns. "The drug companies want to get their message out, and they are looking for people who are willing to let them do that. There is nothing wrong with using drug companies — unless they are misusing the opportunity you're giving them, and taking the programs out of your hands."

Advertising and marketing programs:

• The maxim here, says Osborne, is advertising never goes out soon enough. "Get it on the calendar as soon as you can" — and stick to deadlines. "If you don't respect the deadline, no one else will," he adds. "It's not easy to get the faculty to appreciate all the work that needs to be done to get the program together, but work toward that end. If you're constantly bailing people out all the time, running their syllabus at the last

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minute or whatever, they'll come to expect it and won't believe you when you *do* give them a deadline."

• Want an arresting blurb for your CME brochure? Osborne recommends you approach your scheduled speaker with a dictaphone and ask him or her to take one minute to "convince you why you should close your office for a day and come hear his or her program."

• "Good education is always good marketing," says Osborne. A quality program enhances the reputation of an institution.

• Learn who your constituents are, and go after them. Ask for their input, what programs they want — but don't get too ambitious with new topics. "Most physicians use CME as a personnel needs assessment. They aren't necessarily attending to learn something new, but to see if what they are already doing is up to current acceptable levels of practice."

• Steer clear of false advertising — those claims that, "following this program you will know how to do this procedure or know how to perform this or that technique." "Chances are, they won't," says Osborne. "There is not enough time in a CME program to turn participants into experts on a subject — just to acquaint them with what's available out there now, or what they may not know yet about a subject."

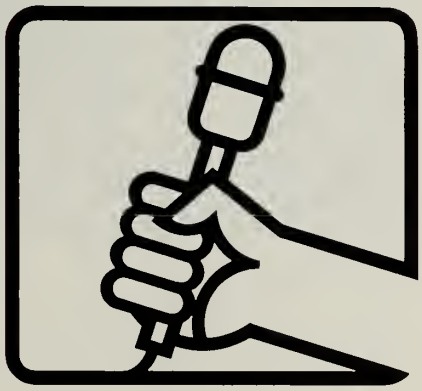
• Don't make your program look cheap — but discounts for early registration or package deals, where lower rates for a series (as opposed to a selection of separate courses) are offered, is a good idea. "Just be careful how you advertise it. You don't want to be talking about penalty fees for those who wait and register at the door."

• Be sure to mention in your advertising that a minimum of participants is needed in order to hold the course. "Otherwise, you're liable to be refunding the super-saver airline tickets of those who signed up for the program you had to cancel."

• Keep participants happy. People are more concerned, says Osborne, about how they're treated than by what they learn. If they feel comfortable at your programs, they'll be back . . . and they'll spread the word.

Selecting a speaker:

• "Frankly, most participants who sign up for a seminar don't know who the speaker is, unless the speaker is a very well-known name or happens to be in the same specialty," says Osborne. Outside their specialty, however, participants are going to look at the speaker's credentials before



determining whether or not to attend. "The better credentials, the better the turnout," Osborne notes. That's not to say the speaker from the University of Illinois is less qualified than the Harvard or other Ivy League college professor. But it's a CME programmer's reality that the latter will be a bigger draw.

Format:

• An auditorium is still the best mechanism to get a lot of information to a lot of people. "Don't delude yourself that by designing your program into small discussion groups that there is any interaction going on. Generally these 'discussions' involve a speaker lecturing to 10 people instead of 100," Osborne says.

• While it *is* cheaper to have one person speaking to 100, Osborne recommends scheduling some interactive learning from time to time. These simulated training experiences (with mannequins or real-life, volunteer "patients") have a way of becoming very real to the participants, and they learn more than they do in a lecture situation, he claims.

Accreditation:

• Don't believe that the accreditation team is going to find something wrong with your program, no matter how perfect it is, because it's not true. "Yes, there are surveyors who may look at things from a different perspective than you, but they know what they're doing, and they're not out to get you," says Osborne.

• "Don't screw up a good Category II course because you want to make it a Category I."

• Don't get carried away with documentation, learning objectives and pre- and post-tests. "A paragraph about the program that makes sense is better than a pile of trash," Osborne says.

• Don't expect the ACCME or other accrediting body to provide you with examples of how something should be done. "That's because laziness is rampant and an example provided by accreditors would be immediately adopted as 'the form,' " says Osborne.

• Finally, prepare yourself and be ready to answer questions, but then relax. "Essentials are not that hard to comply with. If you have a high-quality program, they're probably already there. And documentation is not that tough," he claims.

Basically, Osborne concludes, it is the CME planner's job — as thankless as it often appears to be — to keep CME events running smoothly. He sums up this way:

"If they don't even know you're there — or why they have you around — you're doing your job correctly." — *Karen S. Edwards*

OHIO MEDI-SCENE

Reporting live from the OMPAC Luncheon

Take it from NBC Correspondent Douglas Kiker, sometimes guest speakers don't get any respect. Once at a speaking engagement in Rochester, New York — after the dinner plates were being carted away and dessert was being served — the head of the event turned to Kiker and said, "Should we let these people relax and enjoy their dessert or are you ready to start talking?"

But judging by the audience response at the 1989 OMPAC Luncheon, Kiker has little trouble keeping people entertained. Kiker was this year's featured speaker at the OMPAC Luncheon, held during the OSMA Annual Meeting in Dayton.

Leave it to "an old newspaper man," as Kiker calls himself, to have a seemingly endless scroll of anecdotes to share . . . There's an old story about what would happen if Moses came down and gave a news reporter the Ten Commandments, Kiker began. That night on the evening news the commentator would say, "Good evening. Today Moses came down from heaven and gave us the Ten Commandments. I now have a report on three of the most important . . ."

Kiker entertained the OMPAC guests with a variety of reporting stories about presidential elections, the Vatican and the Washington crowd, among other things.

A certain amount of distrust exists between the public and the media, Kiker continued. "We don't have enough time on television to give you the news," he said. Minus commercials, there's only "22 minutes to say what went on in the world today." And as only one correspondent among many, "I fight for 15 seconds," he added.

Douglas Kiker

Aside from his humorous anecdotes, Kiker did display a more serious side. "These are good times for most," he said. "But they are also uneasy and uncertain times."

He rattled off a chain of unsettling questions about the modern world: Will there be a recession? Have we been living at the expense of tomorrow? Will we lose our birthright to foreign countries?

"It's difficult to make predictions," he said. "Human knowledge expands at such a rapid rate."

But one thing's for certain: It's a different world that we live in today . . . the Pacific Basin has emerged as a financial power, China's doors are opening and the Soviet Union is undergoing a second revolution of sorts, he explained.

"There's some questions about the role of the United States . . . how we fit in," he pointed out. "We're a changing nation in a changing world. And change promulgates change," he continued.

The world that Kiker described is an uneven one, perhaps made more understandable by this oft-repeated phrase: "They were the best of times, they were the worst of times . . ."

On the plus side, the U.S. is not at war, unemployment and inflation rates are down, and the country is in its seventh year of prosperity. "Today, instead of gloom, we have boom," Kiker said.

On the other hand, he pointed out that the rich are getting richer,

wage increases are not keeping pace with current inflation, and the country is being plagued by problems such as AIDS, drugs and the crime rate.

He summed up with some thoughts on the following subjects:

College campuses: "These are the good old days on college campuses, by and large. The greatest single controversy is the quality of food in the college cafeteria."

Old presidents . . . "No president since FDR could stir people like Reagan . . ."

New presidents: "Bush defined Dukakis through negative advertising before Dukakis defined himself . . . Bush's major opponent is economic reality . . . It will be tougher for him to govern than it was for him to win . . . We have found we like George Bush . . . we should give the man a chance . . ."

Presidents in general: "We don't give our presidents much of a chance. We invade their privacy, we kill them — or try to — we ridicule them . . ."

The state of the nightly news: "The natural inclination is to make soft butter out of it . . . We do write it ourselves; we paste the stories together with scotch tape."

The state of the nation: "The U.S. still has some scars that are healing," he said — Watergate, the stock market collapse, Vietnam, the recession of the early '80s . . . "The interest on the federal deficit is the nation's third largest expenditure . . . Nothing less than a tax increase is going to solve our deficit . . . Our current prosperity was bought on credit and I think that bill is going to have to be paid."

After some of these somewhat somber observations, Kiker was ready to sign off — perhaps remembering what he had mentioned earlier, that "the worst thing a correspondent can do is start thinking." — *Deborah Athy*

OMPAC Luncheon awards

Membership in the Ohio Medical Political Action Committee (OMPAC) increased by 17% in 1988, OMPAC Chairman Jerome Kimmelman, MD told approximately 350 physicians and physician spouses at the 1989 OMPAC Luncheon, which was held during the OSMA Annual Meeting in Dayton. "But we won't rest on our laurels," he vowed.

The luncheon marked the 25th anniversary of the creation of OMPAC. "The need (for physician involvement) was apparent then and now is painfully obvious," Dr. Kimmelman pointed out.

"I can't understand how we don't have 100% membership," he said. "I challenge all of you who aren't members to make that commitment (to join) today."

OMPAC did earn some laurels for its membership efforts at the luncheon. An American Medical Political Action Committee (AMPAC) representative was on hand to honor OMPAC with several awards. Among state political committees, OMPAC received honors for having the second largest increase in membership over the previous year, the third largest contributions per member and a second in all other events.

Dr. Kimmelman also presented awards for individual efforts to enhance medicine's political environment. W. Jack Lewis, MD, received the OMPAC Distinguished Service Award for his countless hours of commitment to the AMA Council, AMPAC, OMPAC and the OSMA.

Barbara Marshall, the 1989-90 OSMA Auxiliary President, received the OMPAC Physician Spouse Distinguished Service Award for her dedication and contributions to OMPAC, Montgomery County Medical Society Auxiliary and the OSMA Auxiliary. — *Deborah Athy*

OMPAC Chairman Jerome Kimmelman, MD presents 1989 OMPAC awards to Jack Lewis, MD (l.) and Auxiliary President Barbara Marshall.

Delegate registration . . .

Candidate interviews . . .

Informational exhibits . . .

The Annual Meeting: See How It's Run

By Michelle J. Carlson

A convention is a convention is a convention. Or is it? From all outside appearances, the OSMA's Annual Meeting looks like a convention: There are Annual Meeting signs near every door, hall and breezeway, OSMA members wearing OSMA name tags carry tote bags emblazoned with the OSMA seal, and the meeting itself is held in — what else? — a convention center. But, the OSMA Annual Meeting, for all intents and purposes, is *not* a convention. It's a carefully planned, near-perfectly executed meeting where OSMA delegates gather to debate and make thoughtful decisions on OSMA policy. If you're new to the OSMA, or simply unfamiliar with the workings of the Annual Meeting, the weekend can be a little overwhelming, but if you follow just a few tips, attending Annual Meeting needn't be a nightmare. In fact, you just might enjoy it.

It doesn't take a degree in thermonuclear physics to read signs and ask directions, but many who attend the Annual Meeting make it a point to acquaint themselves with the convention center the night *before* that early morning meeting. Even then, some manage to become disoriented — after all, directions sometimes tend to sound like, "Take Elevator A to Escalator 1, turn left into Hallway M, turn right at the second door . . ." Reading the signs that dot the halls and doorways usually helps, but an OSMA staffer is never too far away to answer your questions.

On Friday, attendees who have gotten their bearings usually head directly for the House of Delegates registration desk. In Dayton, registration was conveniently located on the main floor of the convention center, as was the OSMA newsroom and the main office (where, incidentally, OSMA staffers abound). While most attendees are busy registering and

Reference committee hearings . . .

Discussions . . .

Reviewing the resolutions . . .

preparing for upcoming meetings, most new delegates make a beeline for the "New Delegates and Alternate Delegates Briefing Meeting," which is held shortly after registration opens.

At this year's meeting, Donavin A. Baumgartner, Jr., MD, OSMA's now-Immediate Past President, and OSMA's Managing Director, Brent D. Mulgrew, briefed the delegates and alternates on their duties. "On the debate of resolutions," Dr. Baumgartner said, "that should primarily occur Saturday. You should be doing most of your discussion to convince your colleagues at reference committee." Dr. Baumgartner then gave them some basic rules of the House floor, saying, "When you're testifying, give your name and where you're from. And identify who you're speaking on behalf of.

"If you're unsure of how to do something," he continued, "let the chair know what you're trying to do . . . and the chair will try to facilitate it for you."

By late afternoon, delegates and alternates can be found in their district caucus meetings, where members discuss resolutions of particular interest and decide who will attend which of the following day's debates. After a quick break for dinner, the first session of the House of Delegates convenes. There, the outgoing President, in this case, Dr. Baumgartner, presides, listening to various committee reports, bestowing honors on a handful of OSMA members, and delivering his presidential address. The meeting is decidedly short — about two hours — and, for the most part, upbeat. Those who have been to the Annual Meeting before know that there will be plenty of time for debate during the final session.

On Saturday, most delegates find themselves attending — and occasionally testifying at — one or more of the three reference committees. There, numerous resolutions are brought up on the floor for debate and discussion. Once the testimony ends the committee will vote to accept or reject the resolution or refer it to Council.

After reference committee, delegates have the option of

Caucus meetings . . .

District representatives . . .

The House in session . . .

Speaking out . . .

Taking notes . . .

attending the Ohio Medical Political Action Committee's (OMPAC) annual luncheon. This year's luncheon celebrated OMPAC's 25th anniversary and featured well known NBC News correspondent Douglas Kiker, who offered a welcome diversion from the seemingly endless schedule of meetings.

After the luncheon, it's back to work for most, as delegates and alternates once again gather with the other physicians from their district for a chance to meet and interview the candidates for OSMA President-Elect and delegates to the AMA. This year's candidates for President-Elect included William H. Porterfield, MD, J. James Anderson, MD, and John A. Devany, MD.

Once the interviews end, delegates are free for the evening, though many choose to go to the scheduled social event. This year, attendees were treated to dinner at the Engineers Club and the Gershwin musical, "My One and Only" (which, incidentally, was a sell-out — an OSMA first).

Sunday is generally a long day, with district caucus meetings beginning at 8 a.m. sharp. There, delegates receive the reference committees' final reports, which indicate which resolutions have been recommended for acceptance, rejection or referral. Each district discusses the various resolutions and decides whether district members will offer testimony and how members will vote. After a quick lunch, delegates re-register for the final session of the House, which begins at 1 p.m. Generally, because there are so many resolutions to consider and debate is often heated and prolonged, the final session runs well into the night, but this year's meeting proved another OSMA first — it ended promptly at 5 p.m.

The highlight of the final session, of course, is the installation of the new President (this year, William J. Marshall, MD, of Dayton) and the election of delegates to the AMA and of the President-Elect. This year was no exception. Because there were three candidates for President-Elect, delegates were required to vote twice, thus narrowing the field. (The voting probably would've gone smoother and quicker, except that the delegates had to be reminded — good naturedly, of course — how to correctly fill in the circles on their ballots that would indicate their choice.)

When the results were finally tabulated, the OSMA had a new President-Elect — John A. Devany, MD, of Toledo. Shortly afterwards, the final session of the House of Delegates adjourned.

Monday morning finally arrives, only to remind Annual Meeting participants that a full week of work awaits them. The day-to-day grind hasn't stopped just because medical policies had to be made. But most delegates — a little worse for wear and tear, perhaps — take with them from the Annual Meeting the satisfaction of knowing they have made a definite contribution in shaping the policy and furture of organized medicine. **OSMA**

Michelle J. Carlson is the Editorial Assistant for **OHIO Medicine.**

The First Session of the House

By Michelle J. Carlson

"UCR" is a fairly infamous term in the medical profession, but when defined by Donavin A. Baumgartner, Jr., MD, it takes on a whole new meaning.

During his year in office as president, Dr. Baumgartner frequently referred to UCR as "Unity, Communication and Responsibility" in an effort to rally physicians. Apparently, it had an effect. Nowhere was it more evident than at this year's Annual Meeting, held in May in Dayton. Dr. Baumgartner presided over the meeting, which emphasized this new spirit.

The first session of the House of Delegates, a meeting during which many of those physicians active in the OSMA are recognized and honored for their services, gave physician attendees their first chance to show that they are truly united for medicine's cause.

Dale R. Hines, MD, President of the Montgomery County Medical Society, which hosted the first session, opened the meeting by welcoming the delegates. He was especially pleased, he said, that not only was his the host society, but that William J. Marshall, MD, the OSMA's incoming president, is a fellow member of that society.

Dr. Hines then turned the podium over to Ray Gifford, MD, an AMA delegate and a member of its board of trustees, who addressed some concerns of county medical societies. It was apparent from the start that Dr. Gifford, indeed the entire AMA, has embraced Dr. Baumgartner's first directive, that of unity.

"I find that there's some discontent, concern, downright harrassment from the government and other sources . . . and that the AMA is doing nothing about it," Dr. Gifford said. "Nothing could be further from the truth."

As examples, Dr. Gifford mentioned physicians' concerns with PROs, medically unnecessary letters and ICD-9-CM coding.

"All physicians who are being sanctioned by PRO now have a fair shot, thanks to AMA's lawsuit," he said. "Medically unnecessary letters of last year — AMA sued and now Medicare has to come to you, and you get to justify why the service was performed *before* the patient is

Ray Gifford, MD

notified."

As for ICD-9-CM coding, Dr. Gifford said, without AMA's intervention, physicians would have never received an extension from the HCFA allowing them to learn more about coding requirements before their implementation.

"So the AMA is concerned about the problems you're having . . . and we're going to continue to do that." Dr. Gifford also discussed the problems of the uninsured and underinsured and delivering quality health care at an affordable price.

"The only alternative (to our current system)," he said, "is the nationalization of health care. And we're threatened by that." Dr. Gifford said that when compared, say, to the Canadian system, the U.S. health-care system is by far superior.

"The Canadian system is much less responsive to its consumers than the United States. Its hospitals are crumbling. Crumbling . . . There are only 12 MR scanners in Canada. Twelve. Compared to 900 in the United States.

"Not many Americans would tolerate the Canadian system with all its delays," he continued. "Our system is more expensive, perhaps less efficient, but it has the best health care in the world. Americans are living longer than they ever have and their quality of life is better."

After Dr. Gifford's uplifting speech, awards were given to Hart Page, Executive Director Emeritus of the OSMA, who received the American Medical Association 1989 Citation of a Layman for Distinguished Service Award, and to Steven E. Katz, a third-year medical student at Ohio State University, who received the Medical Student Section Research Forum Award for promoting clinical and scientific research.

D. Ross Irons, MD, Past President of the OSMA and chairman of the board of trustees at Physicians Insurance Company of Ohio (PICO), then took the podium and reported that the company "has undergone substantial changes in the last 12 months," and that earnings are up.

For its work during the company's restructuring, Dr. Irons complimented the PICO staff for its diligence and responsiveness to physicians, noting that PICO is now able to guarantee an insurance quote within 24 hours of receiving an application.

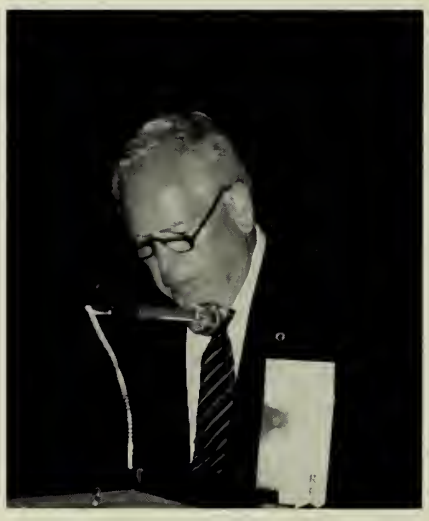
"PICO has withstood the test of fire," he concluded. "The board of directors and staff of PICO assure its mission . . . will be fulfilled."

Expanding on Dr. Baumgartner's UCR theme, Thomas Leech, MD, chairman of the OSMA's Committee on Membership, next reminded members of the House that recruiting new physician members — in other words, uniting them — is a must if the OSMA is to remain a viable, effective organization.

"Membership is still the name of the game. It's important enough to receive departmental status at the OSMA," he said. But despite a membership that numbers some 20,000+ physicians, "There is still a nucleus of some 4,000 to 4,500 physicians who need to be brought into the fold."

Dr. Leech specifically urged that the association encourage women physicians to join and continue to offer dues reductions for physician couples. "Let's unite these groups under one flag," he urged. "We must continue to aggressively pursue new members," while simultaneously serving current members' needs and preserving their loyalty.

The next speaker, Catherine Staton, outgoing President of the OSMA's Auxiliary, chose to illustrate Dr. Baumgartner's second directive — communication.



Thomas Leech, MD

Staton admitted that during her first few months as President, she felt more than a little unsure of herself. "It's not easy being green," she said, quoting Kermit the frog, but "in just 12 short months, I've learned a lot. The Auxiliary has made great strides

forward."

Staton received a standing ovation after noting that for the first time, "The lines of communication between the Auxiliary and the OSMA are really open," and predicting "nothing but smooth sailing and blue skies" next year as William J. Marshall, MD, takes over as President of the OSMA, and his wife, Barbara, heads the Auxiliary.

Dr. Baumgartner then stood and, with the assistance of Staton, presented the AMA-ERF awards, which totaled $82,979.34, to the following medical schools:

- CWRU — $13,749.95
- OSU — $26,273.64
- UC — $22,052.70
- MCO — $6,854.78
- WSU — $4,890.87
- NEOUCOM — $9,157.40

Plaques were then presented to retiring OSMA delegates to the AMA and retiring members of OSMA's various standing committees, and Dr. Baumgartner announced the election of members to the Committee on Nominations.

The Department of Communications then showed a slide show reviewing OSMA activities of the past year, which met with much applause.

At this point, the meeting appeared to be winding down after a brisk, efficient course of business, but of course a first session wouldn't be complete without the outgoing President's reflection on his term in his office, so Dr. Baumgartner once again took the podium.

In his address, Dr. Baumgartner subtly, yet effectively, managed to weave in the principles of the new, improved UCR.

"Tonight," he began, "I'd like to spend a few minutes talking about the state of our profession — where we are, where we are going and what we can, and should, do about it."

Donavin A. Baumgartner, Jr., MD

He addressed the current state of medicine, namely by voicing physicians' concerns: the needs of patients, cost containment, government and third-party regulations, hospital demands, utilization rules . . .

And the frustration physicians often feel. "Perhaps some will say we should take a page from the movie 'Network,' " he said, "in which an anchorman asked his viewers on TV to go to the window and yell, 'I'm madder than hell and I'm not going to take it anymore.'

"I'm sure we all feel like doing just that from time to time," he continued, but "first and foremost, we must remain united. This means being a team player . . . We simply cannot go off disgruntled and quit organized medicine if our personal views do not prevail."

Communication, he stressed, is also of prime importance.

"We need communication with the public, our patients and the government to educate them," he said. "We must combat the misleading publicity over increased health-care costs and explain the reasons — since there are very good reasons — and more importantly, we must point out alternatives."

Physicians, too, he said, have a responsibility to protect the physician-patient relationship. "In protecting the physician-patient relationship, we must remain the patient advocate . . . I have repeatedly tried to make the point to government and third-party payers that physicians react far more to any interference with the doctor-patient relationship than to any arbitrary fee reduction.

"I have said before and will continue to repeat that if we continue to act as the patient advocate, we need not worry one bit about ourselves." While medicine can be a very frustrating profession these days, Dr. Baumgartner remained optimistic and ended on an uplifting note.

"I put it to you," he said, "that the practice of medicine is still an honor and a privilege. All of the many problems are worth the effort to preserve what I hope you still agree is the most noble of professions."

Following Dr. Baumgartner's speech, the late H. Judson Reamy, MD, New Philadelphia, was honored in a memorial resolution for his long-time service as a Tuscarawas County family practitioner and participation in OSMA activities.

Two resolutions were withdrawn, and three submitted by the Hospital Medical Staff Section were assigned to Reference Committee #1. In addition, five of six emergency resolutions were accepted.

Business being finished, the House adjourned at 9 p.m. and physician attendees were invited to attend a reception hosted by the Montgomery County Medical Society. **OSMA**

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The Final Session of the House

By Deborah Athy

The final session of the OSMA House of Delegates got under way Sunday, May 7 at 1:00 p.m. in Dayton. With a hefty agenda of issues to consider — AIDS, Medicare, mandatory drug testing for high school athletes, and RBRVS — the final session could have stretched on until evening, as it has in other years.

Instead, it appeared that the delegates had hammered out most of the chinks in the proposed resolutions on the previous day in reference committee hearings.

Only a few issues prompted rapid-fire discussion on the House floor. The vote on the majority of the resolutions was swift and orderly.

Of a possible 252 OSMA delegates, 224 delegates attended the final session of the House, according to the Credentials Committee.

John A. Devany, MD

The 1989-90 OSMA President-Elect

Once the delegates were counted, the next order of business was the election of the OSMA President-Elect. The nominees were J. James Anderson, MD, Youngstown; John A. Devany, MD, Toledo; and William J. Porterfield, MD, Columbus.

After nominating speeches were made to the House, OSMA delegates cast their ballots, and John A. Devany, MD was declared the new OSMA President-Elect.

In one of the nominating speeches, Dr. Devany was described as "first and foremost, a practitioner who has dedicated himself to medicine . . . He offers hope in two bywords — unity and quality" — unity of physicians and quality of patient care.

Dr. Devany told the House that he will accept the challenges ahead "with heart, humor and humility," in the words of Sir William Osler.

Reference Committee Reports

Next, discussion began on the over 80 resolutions presented before the House. The following is

a synopsis of some of the most important and most-debated resolutions.

- **Amended Resolution 10-89 — Modify Birth Certificates**

This resolution proposed the modification of the current birth certificate in Ohio because of difficulties in clerical handling. Several delegates pointed out that confidentiality should also be considered when creating the new form. The reference committee added an amendment to "preserve patient confidentiality." The House of Delegates adopted the resolution.

- **12-89 — Strengthen the AMA**

This resolution called for a reduction in AMA dues for members of state medical associations. The resolution pointed out that less than 50% of U.S. doctors are AMA members. The resolution was referred to Council.

- **Amended Resolution 15-89 — Co-payments by Medicaid Recipients for Medical Care**

This resolution opposed making the OSMA responsible for the collection of co-payments by Medicaid recipients. One delegate suggested in reference committee that a no-co-payment system could be an incentive to Medicaid recipients to use medical services frivolously. In the final analysis, however, the House of Delegates adopted the resolution with little discussion on the floor.

- **Amended Resolution 17-89 — Ethics in Patient Referral**

This resolution came in response to a resolution by Rep. Fortney Stark (D-Cal.) to put limits on physician referrals of patients. The resolution asks that the OSMA support the AMA's position of opposing legislation that restricts physicians' rights to engage in free enterprise. The House adopted the resolution.

S. Baird Pfahl, MD

- **Substitution Resolution 34-89 — Mandated English Test for Licensure**

This resolution suggests that English competency tests for foreign medical graduates are discriminatory and asks the OSMA to take a stand to this effect. Several physicians spoke in favor of the resolution on the floor of the House, pointing out that the legislature dictates the type of test to be taken. The resolution was substituted on the floor, requesting that the OSMA work with the legislature and the State Medical Board to assess the need for tests of spoken English. The resolution was adopted as substitute.

- **Amended Resolution 39-89 — The Harvard Resource-Based Relative Value Scale (RBRVS)**

This resolution, which requests that the OSMA support the AMA's current RBRVS position, prompted some debate on the floor. One delegate said RBRVS is "essentially a plan to redistribute income." Another said the plan will lead to divisiveness in the profession. But others, such as Janet Bixel, MD, a Columbus internist, said that the scale is needed in some medical specialties. Another delegate pointed out that "a vote for this resolution is not a vote for RBRVS," but simply a show of support for the AMA's direction in this issue. After some debate, the House adopted the resolution.

- **Amended Resolution 44-89 — Clarification of Reporting Procedures Regarding Violations of Medical Practices Act**

This proposes that the OSMA pursue a more clear statement regarding mandatory reporting requirements as stated in the Ohio Revised Code. One physician pointed out that some protection should be afforded to physicians. The resolution was adopted.

- **Amended Substitute Resolution 51-89 — Prohibit Smoking and Use of Tobacco Products**

The issue of tobacco use came up in three separate resolutions — Use of Tobacco in School (51-89), Toward a Tobacco-Free Society (53-89) and Prohibit Smoking in Medical Schools (69-89). Reference Committee #3 combined the three resolutions into Substitute Resolution 51-89, which urged the OSMA to work toward legislation and policies promoting a ban on smoking and tobacco products in hospitals, and health-care and educational institutions, including medical schools. The resolution was adopted.

- **Amended Resolution 54-89 — Waiting Period Before Gun Purchase**

Although this proposal falls outside the usual scope of medical issues, many speakers at the reference committee meeting agreed that the OSMA should go on record in regard to this issue. The issue is also timely, considering there is currently a bill before Congress to require a one-week waiting period before purchasing a gun.

A few speakers said they didn't think the policy would solve the problem of crime in our society. But Edward Kilroy, MD, Cleveland, pointed out that

something had to be done about the control of firearms and that society had to start somewhere. The House adopted the resolution.

- **Substitute Resolution 55-86 — Biomedical Research**

This resolution calls for the OSMA to develop a program to educate the public about the benefits of using animals in research, to support legislation establishing a criminal penalty for interference or damage to biomedical research, and to continue a commitment to the humane treatment of animals in biomedical research.

Supporters of the resolution pointed out that recent actions of activist groups have made biomedical research more difficult. In reference committee, a delegate pointed out that the use of animals in research was recently challenged in Akron. "I suspect this will happen in other areas," he said. "I think it's a good idea that the OSMA have a strong policy." The House adopted the Substitute Resolution.

- **63-89 — Mandatory Random Drug Testing in Competitive Sports**

This resolution prompted discussion in both the reference committee and the House. Past Presidents Thomas Morgan, MD, Gallipolis, and Herman Abromowitz, MD, Dayton, sponsored the resolution, which recommended that the Ohio High School Athletic Association conduct mandatory random drug testing in scholastic high school sports programs.

Dr. Morgan called drug abuse "a public health problem of really unlimited proportions." He acknowledged the complications of mandatory drug testing, such as cost and civil rights issues, but he argued in favor of "the greatest good for the greatest number."

Another delegate who supported the resolution said the OSMA should "take a strong stand on drugs, but also a caring stand. That's what our profession is all about."

During the final session, Dr. Abromowitz emphasized the timeliness of the issue. "There's not a day that goes by that a drug problem — or a death — is not discussed . . . many are young people." He pointed out that athletes are often regarded as heroes by young people. The House adopted the resolution.

- **Amended Resolution 68-89 — Ohio State Medical Board**

In reference committee, testimony on this resolution was favorable. The resolution asks that the OSMA support efforts to strengthen the budgetary needs of the Medical Board by allocating a greater share of current physician licensure fees and future increases in physician licensure fees to the Board. The House adopted the resolution.

- **Amended Resolution 74-89 — New PRO Requirement for Pre-Authorization**

One of the proposals of this resolution requests a "medical justification and clarification of the preauthorization program of the PRO Third Scope of Work and the criteria for approval." The resolution also asks that the OSMA and the AMA seek standards for PRO employees. The House adopted the resolution.

Michael J. Seider, MD

- **Emergency Resolution 03-89 — Medicare PRO Point System**

In reference committee, all speakers strongly supported this resolution to direct lobbying and public relations efforts to HCFA asking to rescind the PRO point system. The resolution points out that the PRO point system could interfere with the quality of patient care. The resolution was adopted.

- **Amended Substitute Emergency Resolution 05-89 — AIDS Legislation**

Last year, the OSMA House of Delegates adopted Substitute Resolution 54-88. As Jack Summers, MD, a member of the OSMA AIDS Task Force, pointed out in reference committee, "Nothing has changed from last year. There is already a sound policy on this issue."

But several major issues of conflict from the previous year crept up again — namely, anonymous testing and informed consent. Stanley Fox, MD, Richmond Heights, in opposition to the concept of anonymous testing, said, "Anonymous testing protects individual rights at the expense of public health."

Brian McNamee, MD, Cleveland, agreed. "Anonymous testing is a unique medical precedent for this one fatal disease," he said. He gave testimony suggesting that anonymous testing sites have not been drawing in high numbers of high-risk individuals for testing.

But according to Thomas Halpin, MD, Ohio Department of Health, "Anonymous testing does work and works very well. But it's not the only tool," he said. He also stressed the importance of counseling and education.

William Keck, MD

"I believe anonymous testing is extremely important," echoed William Keck, MD, Director of the Akron Health Department. "The numbers (of individuals) to these sites are staying relatively strong. We are seeing significant groups of high-risk individuals."

Several speakers spoke against the concept of informed consent, saying that an AIDS test should be regarded in the same manner as other tests. But Michael Para, MD, Columbus, said, "This is exactly the wrong thing to do — to test them (patients) and not tell them. The public would perceive that as we're trying to hide something. We don't need that reputation."

The reference committee took these and other comments into consideration when putting together a substitute resolution on AIDS legislation.

When the AIDS resolution came up for discussion before the House, many of the delegates even proposed that speakers have only one opportunity to speak and should limit their comments to two minutes. The House overwhelmingly approved this motion.

But surprisingly, the substitute AIDS bill was adopted by the House with only a few amendments. The AIDS resolution in its final form reaffirmed much of the OSMA's previous policy in Substitute Resolution 54-88 and in Senate Bill 2.

The anonymous testing position was amended to allow for the re-evaluation of anonymous testing in one year's time as well as periodic public reports from the anonymous testing sites. This amendment was a compromise of sorts and seemingly appeased both sides of the anonymous testing conflict — at least long enough for the resolution to be adopted.

Another amendment proposed that while the OSMA should support protection against unreasonable discrimination in employment, AIDS and other contagious diseases per se should not be included as handicaps under Ohio law.

Medicaid Drug Formulary Report

"The job of representing physicians to the Medicaid Formulary is not getting any easier," said Janet Bixel, MD, Columbus, making her annual report to the House on the Medicaid Drug Formulary. The formulary "is trying to force doctors to do therapeutic substitution," she said. Medications such as diuretics and cough and cold medicines have been removed from the list. "We need to resist these efforts when they are not in the best interest of our patients," she stressed.

The bottom line is to prescribe the least expensive medications when it is effective, she said. "If we can save money in other areas, we can afford to have other drugs" such as anticonvulsants and AZT.

Dr. Bixel also cautioned about the problem of prescribed drugs being abused and reported on the Primary Alternative Care and Treatment Program (PACT), which seeks to limit abuse by Medicaid patients.

The Inauguration of William J. Marshall, MD

After the delegates had decided on this year's resolutions, Past

Dr. Irons administers the presidential oath to Dr. Marshall.

President Herman I. Abromowitz, MD, Dayton, escorted OSMA Auxiliary President Barbara Marshall and her daughter to the podium. Past President D. Ross Irons, MD, Bellevue, administered the presidential oath and presented the presidential medallion to Dr. Marshall.

Dr. Marshall then presented the presidential plaque, gavel and shadowbox to the new OSMA Immediate Past President, Donavin A. Baumgartner, Jr., MD, and a replica of the presidential medallion to Mrs. Marilyn Baumgartner.

Dr. Marshall gives the presidential address to the 1989 OSMA House of Delegates.

The Presidential Address

Dr. Marshall then took the opportunity to address the House of Delegates as the 1989-90 President of the OSMA. He called the occasion historic — for himself, his family and for the association — pointing out that it is the first time that a husband and wife will serve simultaneous terms as Presidents of the OSMA and the OSMA Auxiliary. "I stand here honored, humbled and searching for equanimity," he said.

He and his wife chose a triangle as the symbol to represent their dual presidential administrations. The physicians of Ohio are on one side of the triangle, he explained, and the auxilians are on the other. "Together the force . . . will form the base of our triangle, which portends an equation for change. This symbol represents our common philosophy which will be woven through the threads of our work in the next 12 months."

And how will this philosophy be translated into action? "First and foremost," he said, "on all issues facing our two organizations, we will emphasize unity and teamwork."

Dr. Marshall said there is a "solidarity of purpose" that bonds all physicians, whether they practice in the big city or in rural

Election Results

President-Elect (for a one-year term) — John A. Devany, MD

Councilors (from even-numbered districts for two-year terms)

Second District — Walter A. Reiling, Jr., MD

Fourth District — Su-Pa Kang, MD

Sixth District — Robert C. Reed, MD

Eighth District — John F. Kroner, Jr., MD

Tenth District — Claire V. Wolfe, MD

Twelfth District — Jack Summers, MD

Delegate to the AMA (serving a term commencing May 7, 1989 and ending December 31, 1989) — Lee J. Vesper, MD

Delegate to the AMA (serving a term commencing January 1, 1990 and ending December 31, 1991)

John E. Albers, MD
Donavin A. Baumgartner, Jr., MD
A. Robert Davies, MD
John J. Gaughan, MD
Edward G. Kilroy, MD
Henry G. Krueger, MD
Joseph Sudimack, Jr., MD
Lee J. Vesper, MD
Claire V. Wolfe, MD

Alternate Delegate to the AMA (elected by the OSMA Medical Student Section for a one-year term) — Audrey Ludwig, Cincinnati

Alternate Delegate to the AMA (serving a term commencing May 7, 1989 and ending December 31, 1990) — J. James Anderson, MD

Alternate Delegate to the AMA (serving a term commencing January 1, 1990 and ending December 31, 1991)

John A. Devany, MD
Stephen T. House, MD
D. Ross Irons, MD
William T. Paul, MD
Jack Summers, MD
Frederick T. Suppes, MD
Owen E. Johnson, MD

Alternate Delegate to the AMA (serving a term commencing May 7, 1989 and ending December 31, 1989)

Stephen T. House, MD
Frederick T. Suppes, MD

Alternate Delegate to the AMA (serving a term commencing January 1, 1990 and ending December 31, 1990) — Edmund W. Jones, MD

"Our ultimate goals are to provide necessary services to our membership, enhance the meaning of belonging and to improve the quality of life for Ohio's citizens."

areas. Physicians must come together to resolve problems facing medicine, he pointed out.

"Unity promotes concord," he continued. "Our ultimate goals are to provide necessary services to our membership, enhance the meaning of belonging and to improve the quality of life for Ohio's citizens."

He outlined some of the Auxiliary's continued goals for the year ahead — adolescent health issues, including AIDS, teen pregnancy, tanning hazards and smokeless tobacco.

Dr. Marshall recalled that Hippocrates said that the public spirit of physicians should extend beyond patient care to the community and society at large. He asked physicians to call upon this spirit in their efforts regarding such issues as tobacco use, the uninsured and the homeless.

He pointed out that the homeless have a high prevalence of medical and mental health-care problems. "Our goal will be to understand the special health problems associated with homelessness and devise an overall strategy to provide health services to manage their specific health needs."

The ever increasing number of individuals without medical insurance is another priority, he said. "If this problem is not resolved, it will erode the very principles on which our health system has been built."

He said that the political environment facing medicine for the rest of the century necessitates a strong grass-roots legislative effort. To this end, he congratulated the OSMA Auxiliary on its "Day at the Legislature."

Dr. Marshall's family join the members of the House in congratulating Dr. Marshall.

Dr. Marshall called upon OSMA members to become involved in political campaigns. "As a constituent, the relationship you forge with your legislator can help determine how these (political) decisions are made."

He touched upon the rapidly changing medical environment and the biotechnical issues that go along with progress. Upon Dr. Marshall's request, William Kose, MD, Chairman of the OSMA's Judicial and Professional Committee, will take the lead in studying some of these ethical issues.

Dr. Marshall said he has also formed a new committee — the Committee on Relations With Third-Party Payors and Government — to sort out some of the issues regarding the influence of third-party payors on the health-care system. The committee will be chaired by Immediate Past President Donavin A. Baumgartner, Jr., MD.

"There are many problems facing our health-care system today that our forefathers didn't even imagine," Dr. Marshall concluded. "But by identifying these problems and working together with the Auxiliary, we *can* make a difference . . . Physicians Plus Auxilians — we are truly an equation for change." **OSMA**

Deborah Athy is Associate Editor of **OHIO Medicine.**

Minutes of the First Session

The first session of the House of Delegates of the Ohio State Medical Association was convened at 7:10 p.m. Friday, May 5, 1989 in Room 101 of the Dayton Convention Center by Donavin A. Baumgartner, Jr., MD.

Dr. Baumgartner led the Pledge of Allegiance to the flag, then called on Charles G. Adams, MD, Eleventh District Councilor of the OSMA, to lead the invocation.

Members of the speakers table were then introduced to the House by Dr. Baumgartner. Those seated at the table were as follows: Joseph Sudimack, Jr., MD, Columbus, Secretary-Treasurer; D. Ross Irons, MD, Bellevue, Immediate Past President; W.J. Lewis, MD, Dayton, OSMA Parliamentarian; D. Brent Mulgrew, JD, Managing Director; Herbert E. Gillen, Executive Director; William J. Marshall, MD, Dayton, President-Elect; Charles G. Adams, MD, Invocation Speaker; and Dale R. Hines, MD, Dayton, President, Montgomery County Medical Society.

Dr. Hines welcomed the delegates, alternate delegates and guests to Dayton on behalf of the Montgomery County Medical society, and said he was the third Montgomery County president to welcome the OSMA to Dayton. He reported that the society was especially proud of local physician William J. Marshall, MD, and of Mrs. Barbara Marshall, who will serve this year as President of the OSMA and OSMA Auxiliary respectively. He invited all in attendance to a reception on their behalf, following the close of the first session.

1988 Minutes Approved

The minutes of the 1988 sessions of the House of Delegates, as published in the August 1988 issue of *OHIO Medicine* were approved by official action.

Report of the Credentials Committee

Janet K. Bixel, MD, Columbus, Chairman of the Credentials Committee, reported that, of 252 delegates eligible to be seated and vote, 166 were registered and present at the first session.

Introduction of Member, AMA Board of Trustees

Dr. Baumgartner introduced Ray W. Gifford, MD, Cleveland, a member of the AMA Board of Trustees. Dr. Gifford discussed the AMA response to such issues as peer review, maximum allowable costs, health care for the uninsured and health-care rationing. He indicated that the AMA is concerned about these problems, and is doing its best to protect physicians from further intrusion into their practices.

He also mentioned that politicians and business leaders are looking to the nationalization of health care, and, more specifically, adopting a plan similar to the Canadian health-care system, as a solution to these problems. However, Dr. Gifford pointed out that the perception of this system is superficial and ill-informed, that, while the care Canadians receive is free, a lack of technology, "rationing by queues," and long waiting periods for health care combine to form a heavy price tag for Canadian citizens. He concluded by saying that while America's health-care system may need some fine-tuning, it is not in need of a major overhaul — that the quality of life in America is better than ever, and he urged that "we do not become victims of our own success."

Introduction of Out-of-State Guests

Dr. Baumgartner introduced the presidents of the following out-of-state medical associations, who were in attendance: Fred W. Dahling, MD, New Haven, Indiana, President, Indiana State Medical Association, and Mrs. Dahling; Nelson B. Rue, MD, Bowling Green, Kentucky, Chairman of the Board, Kentucky Medical Association, and Mrs. Rue; Gerald L. Andriole, MD, Hazelton, Pennsylvania, President, Pennsylvania Medical Society, and Mrs. Andriole; William M. Atkinson, MD, Parkersburg, West Virginia, President, West Virginia State Medical Association, and Mrs. Atkinson; and William L.

Treacy, MD, Milwaukee, Wisconsin, President, State Medical Society of Wisconsin, and Mrs. Treacy.

Representatives from the AMA were also in attendance, and Dr. Baumgartner introduced the following individuals to the House: Larry Jellen, Vice President of Marketing, AMA; Susan Kelsey, Department of Membership Development, AMA; John Kasper, Department of Professional Relations, AMA; and George McGee, Mississippi, of the Young Physician Section, AMA, and Mrs. McGee.

Introduction of OSMA Past Presidents

Dr. Baumgartner introduced the following Past Presidents of the OSMA: James L. Henry, MD, Grove City; John J. Gaughan, MD, Cleveland; Thomas W. Morgan, MD, Gallipolis; Robert G. Thomas, MD, Elyria; Stewart B. Dunsker, MD, Cincinnati; S. Baird Pfahl, Jr., MD, Sandusky; A. Burton Payne, MD, Ironton; Herman I. Abromowitz, MD, Dayton; and D. Ross Irons, MD, Bellevue.

Introduction of Past Members of the OSMA Council

Past members of the OSMA Council were then introduced to the House by Dr. Baumgartner. Those in attendance were: David A. Barr, MD, Lima; Theodore J. Castele, MD, Cleveland; William Dorner, Jr., MD, Akron; Stephen P. Hogg, MD, Cincinnati; Edward G. Kilroy, MD, Cleveland; Joseph L. Kloss, MD, Akron; Thomas R. Leech, MD, Lima; W.J. Lewis, MD, Dayton; Benjamin H. Reed, MD, Wauseon; and Carl E. Spragg, MD, New Concord.

Special Introductions

Dr. Baumgartner introduced Hart F. Page, OSMA's Executive Director Emeritus, and read a resolution offering him the congratulations of the House upon being made a recipient of the AMA's Layman of the Year award. A copy of the resolution was presented to Page by Dr. Baumgartner.

Dr. Baumgartner then introduced the winner of the Second Annual OSMA Medical Student Research Forum — Steven E. Katz, a third-year student at OSU's College of Medicine.

PICO Report

Following the introduction of D. Ross Irons, MD, Bellevue, Chairman of the Board of Directors of PICO, by Dr. Baumgartner, Dr. Irons gave a brief report on the state of the company. He said that substantial changes at PICO over the last 12 months have led to a lean, efficient and innovative company, with long-term financial stability. However, he added that new challenges and opportunities await, and that PICO's staff will continue to work to find better ways of reaching physicians.

Membership Outreach Program

Dr. Baumgartner introduced Thomas R. Leech, MD, Lima, Chairman of the OSMA Committee on Membership, who reported that OSMA's current membership stands at 20,925 members (active, retired and student members) and named the winners of this year's membership recruitment campaign: First-place winner — Louis Kovacs, DO, Stark County; second-place winner — Claire Wolfe, MD, Franklin County; third-place winners (a tie) — Donavin A. Baumgartner, Jr., MD, Cuyahoga County, and George Ewing, MD, Stark County.

Report of the Immediate Past President of the OSMA Auxiliary

Dr. Baumgartner introduced Catherine Staton of Springfield, Ohio, who was escorted to the rostrum by her husband, Harvey Staton, MD. She presented Dr. Baumgartner and Executive Director Herbert Gillen with four-leaf clover paperweights. She reported that the Auxiliary has made great strides forward this year, with Auxilians seated at the OSMA Council table and joining the OMERF Board. She said the Auxiliary welcomed Guernsey County back as a charter county this year, and that the Auxiliary's programs have been promised additional monetary support this year by the OSMA.

Presentation of AMA-ERF Checks

Dr. Baumgartner, assisted by Staton, then presented AMA-ERF checks to the representatives of the following Ohio medical schools: Case Western Reserve University School of Medicine, Cleveland; University of Cincinnati College of Medicine, Cincinnati; Ohio State University College of Medicine, Columbus; Medical College of Ohio at Toledo; Northeastern Ohio Universities College of Medicine, Rootstown; Wright State University School of Medicine, Dayton. Contributions to Ohio's six medical schools from AMA-ERF totaled $82,979.34.

Presentation of Plaques to Retiring Members of the Council

The following members of the OSMA Council received plaques in appreciation for their services to the association: D. Ross Irons, MD, Bellevue; Thomas R. Leech, MD, Lima; Richard Steinman, Sylvania; Louis A. Cannon, MD, Cincinnati (in absentia).

Presentation of Plaques to Retiring Members of the Ohio Delegation to the AMA

The following retiring members of the Ohio Delegation to the AMA then received plaques in appreciation for their service:

Robert G. Thomas, MD, Elyria; B. Leslie Huffman, Jr., MD, Maumee (in absentia): J. Hutchison Williams, MD, Columbus (in absentia).

Certificates of Appreciation

Dr. Baumgartner announced the retirement of the following members of standing committees, and chairmen of special committees:

Dr. J. James Anderson, Youngstown, Chairman, Committee on Auditing and Appropriations
Dr. John A. Devany, Toledo, Chairman, Auxiliary Advisory Ad Hoc Committee
Dr. Thomas R. Leech, Lima, Chairman, Committee on Membership
Dr. Harry H. Fox, Cincinnati, Chairman, Committee on Art and Culture
Dr. Frederick H. Davidorf, Columbus, Chairman, Journal Advisory Committee
Dr. Walter A. Daniel, Tiffin, Chairman, Committee of Membership Insurance Plans
Dr. Richard Villarreal, Wheelersburg, Chairman, Task Force on Health Insurance Plans
Dr. Walter W. Jones, Martins Ferry, Member, Committee on Art and Culture
Dr. George D. Clouse, Columbus, Member, Committee on Art and Culture
Dr. George H. Dietz, Youngstown, Member, Committe on Art and Culture
Dr. Wilma F. Bergfeld, Cleveland, Member, Committee on Communications
Dr. Janet M. Blanchard, Mentor, Member, Committee on Communications
Dr. Luther W. High, Millersburg, Member, Committee on Communications
Dr. D. Ross Irons, Bellevue, Member, Committee on Communications
Dr. K. William Kitzmiller, Cincinnati, Member, Committee on Communications
Dr. Jerome A. Logan, Kettering, Member, Committee on Communications
Dr. Ronald J. Ross, Cleveland, Member, Committee on Communications
Dr. Mary Jo Welker, Columbus, Member, Committee on Communications
Dr. Edward T. Bope, Columbus, Member, Committee on Education
Dr. David Jackson, Columbus, Member, Committee on Judicial and Professional Relations
Dr. Arlene L. Kagner, Dayton, Member, Committee on Membership
Dr. Victor M. Bello, Chagrin Falls, Member, Committee on Membership
Dr. Ronald E. Kendrick, Columbus, Member, Committee on Membership
Richard Steinman, Sylvania, Member, Committee on Membership

Reference Committee Chairman Announced

The following House of Delegates Reference Committee chairmen were announced by Dr. Baumgartner: Credentials of Delegates — Janet K. Bixel, MD, Franklin County; Tellers and Judges — J. Steven Polsley, MD, Champaign County; Resolutions Committee No. 1 — Bruce F. Andreas, MD, Geauga County; Resolutions Committee No. 2 — Owen E. Johnson, MD, Franklin County; Resolutions Committee No. 3 — Raymond J. McMahon, Jr., MD, Stark County.

Election of Committee on Nominations

The House of Delegates nominated and elected the following persons, pursuant to the OSMA Bylaws, one from each district, for the Committee on Nominations: First District — Lee J. Vesper, MD; Second District — Herman I. Abromowitz, MD; Third District — Richard L. Faler, MD; Fourth District — Richard J. Wiseley, MD; Fifth District — John J. Gaughan, MD; Sixth District — James A. Lambert, MD; Seventh District — Nan M. Bissell, MD; Eighth District — Walter Wiekliewicz, MD; Ninth District — A. Burton Payne, MD; Tenth District — Paul S. Metzger, MD; Eleventh District — John W. Thomas, MD; Twelfth District — Joseph L. Kloss, MD.

Dr. Baumgartner then announced that under the system of rotation approved by the House of Delegates in 1963, The chairman of the committee this year would be the delegate from the Fourth District, Richard J. Wiseley, MD.

Dr. Baumgartner then asked the House to direct the Nominating Committee regarding election matters, and the number of delegates and alternate delegates to be elected. The House approved the request.

President's Address

Herbert E. Gillen, Executive Director, OSMA, introduced Donavin A. Baumgartner, Jr., MD to the House. Dr. Baumgartner invited members of the head table to join the House in viewing a slide show, prepared by the Department of Communications. Following the slide show, Dr. Baumgartner gave his presidential address which reiterated his theme of "Unity, Communication and Responsibility."

In his address, he mentioned the importance of balancing patient needs with government and third-party regulations, hospital demands, competition and utilization reviews. To achieve this balance, he stressed that physicians must remain united, that divide-and-conquer tactics used on the medical profession have been successful in other countries, including Great Britain and

Canada. He also said that medicine needs to publicize what it does, open lines of communication and develop allies.

Following his address, Dr. Baumgartner received a standing ovation from the House.

As a special order of business, Dr. Baumgartner then invited the House to join him in acknowledging its appreciation to OSMA staff.

Memorial Resolution Introduced

The following Memorial Resolution was presented to the House by Carl E. Spragg, MD, New Concord.

WHEREAS, H. Judson Reamy, MD, a Tuscarawas County resident, was born in Louisville, Kentucky in 1926; and

WHEREAS, Dr. Reamy served with honor and distinction as the Seventh District Councilor of the OSMA from 1978 to 1984; and

WHEREAS, Dr. Reamy served as President of the Ohio Academy of Family Physicians in 1976; and

WHEREAS, Dr. Reamy served as Alternate Delegate to the OSMA House of Delegates from 1972 to 1974; and served as Delegate and Alternate Delegate to the American Academy of Family Physicians; and

WHEREAS, Dr. Reamy was a Diplomate of the American Board of Family Practice and served on the Board for six years and was a Fellow of the American Academy of Family Physicians; and

WHEREAS, Dr. Reamy served in the U.S. Public Health Service from 1950 to 1951; and

WHEREAS, Dr. Reamy had a solo family practice in Dover, Ohio from 1953 to 1977; and

WHEREAS, Dr. Reamy raised four children as a single parent after the death of his wife in a fire at home; and

WHEREAS, Dr. Reamy served on the Tuscarawas County Board of Mental Retardation from 1969 to 1976; and

WHEREAS, After this distinguished career, Dr. Reamy died on January 3, 1989; therefore be it

RESOLVED, That the House of Delegates of the Ohio State Medical Association recognizes Dr. Reamy's dedication and contributions to medicine and the community and expresses its sympathy to his family.

Dr. Baumgartner then asked permission of the House for immediate action on the memorial resolution without referral and the resolution was adopted unanimously by the House.

Introduction of Resolutions

Dr. Baumgartner announced that since the resolutions had been printed and distributed to the members of the House prior to the meeting, and the assignment of resolutions to the Resolutions Committee had also been presented to the House in writing, individual introduction of the resolutions would be waived, unless there were objections voiced by the House. There were none, and the reading of the resolutions was waived.

Dr. Baumgartner then announced that Resolutions 46-89 and 49-89 had been withdrawn, and that Resolutions 73-89, 74-89 and 75-89 from the Hospital Medical Staff Section had been assigned to Resolutions Committee No. 1.

Committee on Emergency Resolutions Report

Dr. Baumgartner announced that six Emergency Resolutions were submitted to the Committee on Emergency Resolutions. Of the six, five were accepted as timely. Emergency Resolution No. 2-89, News Media Access to New Scientific Developments, was referred to Reference Committee No. 2; Emergency Resolution No. 3-89, Medicare PRO Point System, and Emergency Resolution No. 4-89, Health Insurance Plans, were sent to Reference Committee No. 1; and Emergency Resolution No. 5-89, AIDS Legislation, and Emergency Resolution No. 6-89, HIV Infection, were both referred to Reference Committee No. 3.

Action Report on 1988 Resolutions

Dr. Baumgartner announced that a report on the follow-up work on 1988 resolutions was given to all Delegates and Alternate Delegates in their handbook — Action Report on 1988 Resolutions.

House Recessed

Following announcements of Reference Committee meeting rooms, and a reminder of the Montgomery County Medical Society reception, honoring Dr. and Mrs. William J. Marshall, the House recessed until the final session, 1:00 p.m., Sunday, May 7, 1989. OSMA

Index to Actions on Resolutions

Reference Committee #1
Resolutions 01-89 to 26-89, 73-89 to 75-89 and Emergency Resolutions No. 03-89 and 04-89.

Reference Committee #2
Resolutions 27-89 to 50-89, Report A-1989 and Emergency Resolution No. 02-89.

Reference Committee #3
Resolutions 51-89 to 72-89 and Emergency Resolutions No. 05-89 and 06-89.

Minutes of the Final Session, OSMA House of Delegates

The final session of the House of Delegates was convened at 1:10 p.m. on Sunday, May 7, 1989. Dr. Baumgartner called the meeting to order.

INTRODUCTION OF HONORED GUESTS

James Anderson, MD, Oakbrook, Illinois, representing the Illinois State Medical Society, and Mrs. Anderson were introduced by Dr. Baumgartner.

REPORT OF CHAIRMAN OF THE CREDENTIALS COMMITTEE

Janet K. Bixel, MD, Franklin County, Chairman of the Credentials Committee, reported that out of 252 delegates eligible to vote, 224 were present, credentialed and seated.

MEDICAID REPORT

Dr. Bixel then presented a report on the Medicaid Drug Formulary to the House.

ELECTION OF PRESIDENT-ELECT

Dr. Baumgartner called for nominations for the office of President-Elect. Robert C. Reed, MD, Alliance, placed in nomination J. James Anderson, MD, Councilor of the Sixth District. The nomination was seconded by Herman Abromowitz, MD, Dayton.

Leo Clark, MD, Toledo, placed in nomination John A. Devany, MD, Toledo, Councilor of the Fourth District. The nomination was seconded by William Dorner, MD, Akron. Claire V. Wolfe, MD, Columbus, placed in nomination H. William Porterfield, MD, Columbus, Councilor of the Tenth District. The nomination was seconded by S. Baird Pfahl, MD, Sandusky. There were no nominations from the floor, and a written ballot was ordered. Dr. John A. Devany was elected President-Elect. Dr. Anderson and Dr. Porterfield congratulated Dr. Devany, and thanked those who supported their candidacy. Dr. Devany expressed his thanks to the House, and was seated at the head table.

REPORT OF THE NOMINATING COMMITTEE

Richard J. Wiseley, MD, Chairman of the Nominating Committee, was called to the podium. The report of the Nominating Committee was presented to the House. The House approved the recommended candidates by acclamation.

For Councilors from the even-numbered districts, for a two-year term, commencing May 8, 1989: Second District — Walter A. Reiling, Jr., MD; Fourth District — Su-Pa Kang, MD; Sixth District — Robert C. Reed, MD; Eighth District — John F. Kroner, MD; Tenth District — Claire V. Wolfe, MD; Twelfth District — Jack L. Summers, MD.

For Delegate to the American Medical Association, to serve a term commencing May 7, 1989 and ending December 31, 1989 — Lee J. Vesper, MD, Cincinnati.

For Delegate to the American Medical Association, to serve a term commencing January 1, 1990 and ending December 31, 1991: John E. Albers, MD, Cincinnati; Donavin A. Baumgartner, Jr., MD, Cleveland; A. Robert Davies, MD, Columbus; John J. Gaughan, MD, Cleveland; Edward G. Kilroy, MD, Cleveland; Henry G. Krueger, MD, North Olmsted; Joseph Sudimack, Jr., MD, Columbus; Lee J. Vesper, MD, Cincinnati; Claire V. Wolfe, MD, Columbus.

Audrey Ludwig, Cincinnati, was elected by the OSMA Medical Student Section as an Alternate Delegate for one year, commencing March 5, 1989, in accordance with Chapter 5, Section 7 of the OSMA Bylaws.

For Alternate Delegate to the American Medical Association, serving a term commencing May 7, 1989 and ending December 31, 1990, J. James Anderson, MD.

For Alternate Delegate to the American Medical Association, serving a term commencing January 1, 1990 and ending December 31, 1991: John A. Devany, MD, Toledo; Stephen T. House, MD, Dayton; D. Ross Irons, MD, Bellevue*; William T. Paul, MD, Columbus; Jack Summers, MD, Akron; Frederick

T. Suppes, MD, Cleveland; Owen E. Johnson, MD, Columbus.

For Alternate Delegate to the American Medical Association, serving a term commencing May 7, 1989 and ending December 31, 1989 — Stephen T. House, MD, Dayton and Frederick T. Suppes, MD, Cleveland.

For Alternate Delegate to the American Medical Association, serving a term commencing January 1, 1990 and ending December 31, 1990 — Edmund W. Jones, MD, Cincinnati.

REPORT OF RESOLUTIONS COMMITTEE NO. 1

Dr. Bruce E. Andreas, MD, Geauga County, Chairman, presented the report of Resolutions Committee No. 1. The House took action on the report as follows:

AMENDED RESOLUTION NO. 01-89
Resolution of Commendation

RESOLVED, That staff attorneys D. Brent Mulgrew and Douglas Graff of the Ohio State Medical Association and Bill Todd and Terri Smiles of the law firm Porter, Wright, Morris and Arthur, be commended for drafting the Ohio Hospital Medical Staff Bylaws at the request of this House of Delegates and doing so in such a prompt and exemplary manner.

By official action, **the House voted to adopt Amended Resolution No. 01-89.**

RESOLUTION NO. 02-89
Hart F. Page, CAE — Recipient of the American Medical Association 1989 Citation of a Layman for Distinguished Service Award

WHEREAS, Hart F. Page, CAE, is a dedicated individual who has worked tirelessly to promote the ideas of medical science, medical education and medical care through his 40 years of service to Ohio State Medical Association; and

WHEREAS, While at OSMA, he pioneered many innovative programs and services to help physicians utilize new technology and assist them in providing high quality medical care to their patients; and

WHEREAS, In 1976, during a professional liability crisis in Ohio, he spearheaded the drive to create an insurance company to provide medical malpractice insurance to Ohio physicians; and

WHEREAS, In addition to his duties for the OSMA, he has always been active in civic and professional organizations. He has served on the State Planning Committee for Health Education in Ohio and is a Past President of the American Association of Medical Society Executives; and

WHEREAS, His dedication to organized medicine and his concern for his fellow man will leave a legacy of hope and faith in the future of medicine for years to come; therefore be it

RESOLVED, That the Ohio State Medical Association House of Delegates congratulate Hart F. Page, CAE, on being chosen to receive the prestigious American Medical Association Citation of a Layman for Distinguished Service for 1989; and be it further

RESOLVED, That a copy of this resolution of congratulations be provided to Hart F. Page, CAE.

By consent, **the House adopted Resolution No. 02-89.**

AMENDED RESOLUTION NO. 03-89
Statement of Commendation and Appreciation to the Staff of the OSMA

RESOLVED, That the Ohio State Medical Association House of Delegates recognizes and accepts the Ohio State Medical Association Medical Student Section's recognition, commendation and praise for the unending leadership, service and commitment of David Torrens, Carol Mullinax, Doug Evans, Carol Maddy, Margaret High-Thomas and the entire staffs of the Department of Administrative and Educational Services, Department of Communications and the Ohio State Medical Association at-large to the OSMA-MSS.

By official action, **the House voted to adopt Amended Resolution No. 03-89.**

RESOLUTION NO. 04-89
Destruction of Medical Records

RESOLVED, That the OSMA Hospital Medical Staff Section set up guidelines for the preservation of hospital records considered vital to the patient's continued medical care; and, be it further

RESOLVED, That these guidelines be transmitted to the OSMA House of Delegates for approval and implementation in all hospital medical record systems.

By official action, **the House referred Resolution No. 04-89 to the OSMA Council.**

AMENDED RESOLUTION NO. 05-89
Gatekeeper Control of Treatment

RESOLVED, That the OSMA request the AMA to support new federal regulations to limit HMOs from using per capita systems that induce gatekeepers to limit patient access to physician care; and, be it further

RESOLVED, That the OSMA keep the physicians of Ohio informed of any such regulations.

By official action, **the House voted to adopt Amended Resolution No. 05-89.**

RESOLUTION NO. 06-89
HMO Guarantee Fund

RESOLVED, That the Ohio State Medical Association seek legislation to require the development of a "guarantee fund" for all health maintenance organizations licensed in the state of Ohio and that the fund be used to protect both the patient and the provider.

By consent, **the House adopted Resolution No. 06-89.**

AMENDED RESOLUTION NO. 07-89
Physician Liability for Managed Health-Care Plans

RESOLVED, That the Ohio State Medical Association seek legislation which would provide that physician members of a managed health-care plan shall not be held liable for any judgment against the plan arising out of the negligence of that plan; and, be it further

RESOLVED, That the OSMA seek legislation to provide that clauses in managed health-care plan agreements which require physicians to be held liable for any judgment against the plan arising out of negligence of that plan (a "hold harmless" negligence clause) shall be declared null and void. ~~at the option of the physician.~~

By official action, **the House voted to amend Amended Resolution No. 07-89, as indicated in capital letters with deletions as noted, and to adopt it as amended.**

SUBSTITUTE RESOLUTION NO. 08-89
Medicare Terminology (Replacing No. 08 & 25)

RESOLVED, That the Ohio State Medical Association request the American Medical Association to make appropriate efforts to cause governmental agencies and Medicare insurance carriers to discontinue making implied medical judgments by use of such phrases as "not reasonable and necessary" and "medically unnecessary services" and instead use the more appropriate and accurate term "non-covered medical services"; and, be it further

RESOLVED, That the Ohio State Medical Association write to each member of the Ohio Delegation to the United States Congress and inform those members of the need to replace the terms "not reasonable and necessary" and "medically unnecessary services" with the more appropriate and accurate term "non-covered medical services."

By official action, **the House voted to adopt Substitute Resolution No. 08-89.**

AMENDED RESOLUTION NO. 09-89
Third-Party Payment, Intrusion Private Practice of Medicine

RESOLVED, That Ohio State Medical Association investigate intrusions and interferences by various third-party payors in patient-physician relationships; and, be it further

RESOLVED, That these intrusions and interferences be actively combated by appropriate legal means; and, be it further

RESOLVED, That Ohio State Medical Association continue its efforts to restore the professional freedom of its physician members in their efforts to provide the highest quality care to all citizens; **AND BE IT FURTHER**

RESOLVED, THAT THE OHIO STATE MEDICAL ASSOCIATION SEEK LEGISLATION TO PROTECT THE PHYSICIAN-PATIENT RELATIONSHIP.

By official action, **the House voted to amend Amended Resolution No. 09-89, as indicated in capital letters with deletions as noted, and to adopt it as amended.**

AMENDED RESOLUTION NO. 10-89
Modify Birth Certificates

RESOLVED, That the Ohio State Medical Association continue in its efforts to influence the Ohio Department of Health and the Division of Vital Statistics and any other necessary proponent agencies to modify the birth certificate in Ohio to preserve patient confidentiality; and, be it further

RESOLVED, that the Ohio State Medical Association work with the Ohio Department of Health and the Division of Vital Statistics to modify the actual form of the birth certificate for ease in clerical handling.

By official action, **the House voted to adopt Amended Resolution No. 10-89.**

AMENDED RESOLUTION NO. 11-89
Compensation for Cognitive Consultative Services to High-Risk Pregnant Patients

RESOLVED, That the Ohio State Medical Association encourage the Ohio Department of Human Services to recognize psychiatric care for high-risk pregnant patients as a compensable service.

By official action, **the House voted to adopt Amended Resolution No. 11-89.**

RESOLUTION NO. 12-89
Strengthen the AMA

RESOLVED, The American Medical Association should reduce dues for the members of state medical associations that pass rules making AMA membership mandatory.

By official action, **the House referred Resolution No. 12-89 to the OSMA Council.**

RESOLUTION NO. 13-89
AMPAC Guidance

By consent, **the House rejected Resolution No. 13-89.**

RESOLUTION NO. 14-89
Removal of Drugs from the Ohio Medicaid Formulary

RESOLVED, That the Ohio State Medical Association strongly encourage the Ohio Department of Human Services to submit to its Pharmacy and Therapeutics Committee all proposals for deletion of drugs from the Ohio Medicaid Formulary; and, be it further

RESOLVED, That OSMA strongly encourage the Ohio Department of Human Services to follow the recommendations of its Pharmacy and Therapeutics Committee regarding which drugs should be in the Ohio Medicaid

Formulary.

By consent, **the House adopted Resolution No. 14-89.**

AMENDED RESOLUTION NO. 15-89
Co-Payments by Medicaid Recipients for Medical Care

RESOLVED, That the Ohio State Medical Association oppose making physicians responsible for collection of co-payments by Medicaid recipients for medical care; and, be it further

RESOLVED, That OSMA notify Ohio's governor, all members of the Ohio Legislature, and the Ohio Department of Human Services of this position.

By official action, **the House voted to adopt Amended Resolution No. 15-89.**

RESOLUTION NO. 16-89
Medicaid Physician Reimbursement

RESOLVED, That the Ohio State Medical Association strongly encourage the Ohio Department of Human Services to develop realistic and appropriate physician reimbursement for Medicaid services, as well as remove the disincentives evident by the burdensome administrative paperwork required; and, be it further

RESOLVED, That the Ohio State Medical Association Department of Legislation work with the Ohio General Assembly to ensure adequate Medicaid funding to ensure patient access and physician reimbursement.

By consent, **the House adopted Resolution No. 16-89.**

AMENDED RESOLUTION NO. 17-89
Ethics in Patient Referral

RESOLVED, That the Ohio State Medical Association support the AMA position opposing legislation which restricts physicians' rights to engage in free enterprise.

By official action, **the House voted to adopt Amended Resolution No. 17-89.**

RESOLUTION NO. 18-89
Simplified Correction for Medicare Carrier Secondary Responsibility

RESOLVED, That OSMA support the efforts of the AMA in arriving at a simplified method of claim payment correction when Medicare carriers identify the primary liability of another insurer; and, be it further

RESOLVED, That this simplified payment correction system eliminate, as much as possible, the involvement of the physician's office and the patient.

By consent, **the House adopted Resolution No. 18-89.**

RESOLUTION NO. 19-89
Simplified Forms for Medicare Billing of Office Lab Work

By consent, **the House rejected Resolution No. 19-89.**

RESOLUTION NO. 20-89
Encouragement of OMPAC Membership

RESOLVED, That OSMA strongly encourage all delegates and alternate delegates to be members of OMPAC.

By consent, **the House adopted Resolution No. 20-89.**

RESOLUTION NO. 21-89
Uncompensated Service to Third-Party Payors

RESOLVED, That the Ohio State Medical Association recommend as a matter of policy to its members the following guidelines; to wit:

1. The *MODE, LOCATION, EXTENT* and *DURATION* of a patient's medical care is to be determined without regard to payment source but based on the mental and physical status of the patient and the reasonably required medical, nursing and ancillary services. The sole individual charged with the responsibility for this determination is, as provided by the laws of Ohio, to be the attending physician.
2. All inquiries by a third-party payor, who is or should be remote to the physician/patient relationship, should be answered only when the physician is satisfied that the insurance company has the appropriate contractual or legal right to such information. This normally would necessitate a signed release by the patient authorizing the release of such information to the third party.
3. Costs of answering excessive inquiries from a third-party payor should be paid by the insurance company or third-party payor. This should include charges for the physician's time as well as the cost of clerical staff to answer the inquiry.
4. All physicians should cooperate with the *patient* in obtaining appropriate reimbursement for medical expenses incurred as part of the physician/patient relationship but only insofar as those requirements for information are not duplicative or excessive.

By official action, **the House referred Resolution No. 21-89 to the OSMA Council.**

RESOLUTION NO. 22-89
AMA Leadership in Medical Economics Education

RESOLVED, That the OSMA-MSS ask the OSMA to request of the AMA that they work with AAMC to (A) publicize the importance of educating physicians and medical students in the area of health-care economics, and (B) promote the establishment of curricula in medical economics at all accredited medical schools; and, be it further

RESOLVED, That the OSMA-MSS ask the OSMA to request that the AMA develop an informational report or pamphlet summarizing the important issues in the field of health-care economics, which describes the relevant AMA publications which are available for purchase, and which will be available to all AMA members upon request; and, be it further

RESOLVED, That the OSMA-MSS ask the OSMA to request of the AMA that they establish an externship/fellowship program within the Division of Health Policy Development for those medical students and physicians who seek additional training and experience in the area of health-care policy analysis and development.

By consent, **the House adopted Resolution No. 22-89.**

SUBSTITUTE RESOLUTION NO. 23-89
Medical Staff Bylaws and Peer Review
(Replacing No. 23, 73 & 75)

RESOLVED, That the House of Delegates endorse the Ohio Model Hospital Medical Staff Bylaws; and, be it further

RESOLVED, That OSMA strongly recommend that *all* organized medical staffs be governed by medical staff bylaws; and, be it further

RESOLVED, The OSMA vigorously oppose any action that would impede or deny an organized medical staff's right or ability to be organized and governed by its own medical staff bylaws; and, be it further

RESOLVED, That OSMA encourage each hospital medical staff to review its peer review and fair hearing process and compare them to those in the Ohio Model Hospital Medical Staff Bylaws to ensure a fair procedure and reduce potential liability; and, be it further

RESOLVED, That the Ohio Model Hospital Medical Staff Bylaws be used as a guide for medical staffs in their credentialing, recredentialing and fair hearing processes.

By official action, **the House voted to adopt Substitute Resolution No. 23-89.**

AMENDED RESOLUTION NO. 24-89
Patient Advocate

RESOLVED, that the Ohio State Medical Association encourage each hospital medical staff to work with its hospital administration to provide a mechanism within the hospital that allows the patient to verbalize concerns through a patient care representative; and, be it further

RESOLVED, that any such patient concerns be reported to the patient's attending physician.

By official action, **the House voted to adopt Amended Resolution No. 24-89.**

RESOLUTION NO. 26-89
House Bill 235 — Mandatory Medicare Assignment

RESOLVED, That the House of Delegates of the Ohio State Medical Association recommend to the OSMA Council that should House Bill 235 be enacted, the OSMA would take immediate court action to nullify same and seek the assistance of Ohio citizens to join in the common cause of preserving the Constitutional rights of both patients and physicians alike.

By official action, **the House referred Resolution No. 26-89 to the OSMA Council.**

AMENDED RESOLUTION NO. 74-89
NEW PRO REQUIREMENT FOR PRE-AUTHORIZATION

RESOLVED, The OSMA and the AMA to seek both medical justification and clarification of the pre-authorization program of the PRO third scope of work and the criteria for approval; and, be it further

RESOLVED, That the OSMA and the AMA seek standards requiring competent, licensed medical professionals to be employed by the PRO for obtaining information for pre-authorization authority, and to require the PRO to define a reasonable period of time spent in the pre-authorization program, as well as to require timely action on requests for pre-authorization; and, be it further

RESOLVED, The OSMA initiate a program of physician education on the pre-authorization program, standards and methods to obtain approval.

By official action, **the House voted to adopt Amended Resolution No. 74-89.**

EMERGENCY RESOLUTION NO. 03-89
MEDICARE PRO POINT SYSTEM

RESOLVED, That the Ohio State Medical Association will direct its lobbying and public relations efforts to HCFA to rescind the PRO joint system; and, be it further

RESOLVED, That the Ohio State Medical Association will educate the public as to the adverse effects of the PRO Point System on medical care; and, be it further

RESOLVED, That the Ohio State Medical Association Delegation will submit this resolution to the American Medical Association Annual Meeting.

By consent, **the House adopted Emergency Resolution No. 03-89.**

AMENDED EMERGENCY RESOLUTION NO. 04-89
Health Insurance Plans

RESOLVED, That the Ohio State Medical Association educate patients to the advantages of health insurance plans in which medical decisions or medical referrals are made solely by doctors of medicine or doctors of osteopathy; and, be it further

RESOLVED, that the Ohio State Medical Association encourage enactment of legislation that prohibits health insurance plans from restricting access of patients to the plan's physicians (doctors of medicine or doctors of osteopathy) by non-MD/DO gatekeepers.

By official action, **the House voted to adopt Amended Emergency Resolution No. 04-89.**

THE REPORT OF RESOLUTIONS COMMITTEE NO. 1, AS A WHOLE, AS

AMENDED, WAS APPROVED BY THE HOUSE.

REPORT OF REFERENCE COMMITTEE 2

Dr. Owen E. Johnson, MD, Franklin County, Chairman, presented the report of Resolutions Committee No. 2. The House took action on the report as follows:

AMENDED RESOLUTION NO. 27-89
Standardization of Data Collection

RESOLVED, That the Ohio State Medical Association work through appropriate means to develop standardized requirements for the collection of patient outcome data by hospitals and physicians.

By official action, **the House referred Amended Resolution No. 27-89 to the OSMA Council.**

AMENDED RESOLUTION NO. 28-89
Confusion Between Transfer and "Patient Dumping"

RESOLVED, That the Ohio State Medical Association, through appropriate communication means, attempt to educate physicians, the public, media, various public officials and others regarding the difference between an appropriate patient transfer and what is referred to as "patient dumping"; and, be it further

RESOLVED, That the Ohio State Medical Association adopt the position that the use of the term "patient dumping" is offensive and should be discontinued; and, be it further

RESOLVED, That a similar resolution be forwarded to the American Medical Association for proposed national implementation.

By official action, **the House of Delegates voted to adopt Amended Resolution No. 28-89.**

AMENDED RESOLUTION NO. 29-89
Patient Transfer

RESOLVED, That the Ohio State Medical Association work through appropriate means to develop model patient transfer forms for use in Ohio by all medical facilities; and, be it further

RESOLVED, That a similar resolution be forwarded to the American Medical Association for proposed national implementation.

By official action, **the House referred Amended Resolution No. 29-89 to the OSMA Council.**

AMENDED RESOLUTION NO. 30-89
Uncompensated Care

RESOLVED, That the Ohio State Medical Association widely communicate to the public the problem of uncompensated care and the ever increasing regulations involving such care as well as the detrimental effect that uncompensated care has on the availability of necessary health-care services to many citizens; and, be it further

RESOLVED, That the OSMA publicize the programs currently instituted to address uncompensated care and pursue additional solutions for dealing with the problem of uncompensated care; and, be it further

RESOLVED, That a similar resolution be forwarded to the American Medical Association for proposed national implementation.

By official action, **the House voted to adopt Amended Resolution 30-89.**

RESOLUTION NO. 31-89
Ban on Fee for Surrogate Motherhood

RESOLVED, That the Ohio State Medical Association Legislative Department seek to influence the legislature to pass a law banning the payment of a fee for the bearing of a child and/or a fee to a mother to purchase her delivered child.

By official action, **the House referred Resolution No. 31-89 to the OSMA Council.**

AMENDED RESOLUTION NO. 32-89
Amend House Bill 790

RESOLVED, That the Ohio State Medical Association Legislative Department lobby for an amendment to House Bill 790, which would eliminate the exemption because of religious tenets and practices for testing for treatable inborn errors of metabolism which can result in mental retardation or other disability.

By official action, **the House voted to adopt Amended Resolution No. 32-89.**

RESOLUTION NO. 33-89
CME Credit for Physician Lecturers

RESOLVED, That the American Medical Association change its CME policies to allow physicians to receive Category I credit on an hour-by-hour basis for giving a lecture at a course which is otherwise approved for Category I CME credit.

By official action, **the House referred Resolution 33-89 to the OSMA Council.**

SUBSTITUTE RESOLUTION NO. 34-89
Mandated English Test for Licensure

RESOLVED, ~~That repeat English competency tests are unfair, illogical and discriminatory and that the Ohio State Medical Association take a firm stand on this issue and help repeal this discriminatory legislation.~~ **THAT THE OHIO STATE MEDICAL ASSOCIATION WORK WITH THE LEGISLATURE AND THE OHIO STATE MEDICAL BOARD TO CHANGE THE CURRENT LEGISLATIVE LANGUAGE FOR ASSESSING ENGLISH CAPABILITY SO AS TO IMPROVE THE MEDICAL BOARD'S FLEXIBILITY IN TESTING FOR SPOKEN ENGLISH.**

By official action, **the House voted to adopt Substitute**

Resolution No. 34-89.

AMENDED RESOLUTION NO. 35-89
Funding for AIDS Patients

RESOLVED, That the Ohio State Medical Association legislative committee work with the Ohio General Assembly to evaluate possible mechanisms for funding to cover the hospitalization and medical treatment for underinsured patients with AIDS and other catastrophic illnesses.

By official action, **the House voted to adopt Amended Resolution No. 35-89.**

AMENDED RESOLUTION NO. 36-89
Generic Drugs

RESOLVED, That the Ohio State Medical Association work with the Ohio State Board of Pharmacy to develop regulations requiring pharmacists to label generic drugs which are substituted for prescribed drugs with the generic name followed by the proprietary name **AS PRESCRIBED** in parenthesis.

By official action, **the House referred Amended Resolution No. 36-89 to the OSMA Council.**

RESOLUTION NO. 37-89
Reporting of Prescription Substitution

By official action, **the House rejected Resolution No. 37-89.**

AMENDED RESOLUTION NO. 38-89
Treatment of Learning Disabilities

RESOLVED, That the Ohio State Medical Association develop a multidisciplinary task force to study the issues of learning disabilities and appropriate diagnostic procedures and treatments; and, be it further

RESOLVED, That this task force consist of but not be limited to pediatricians, family physicians, neurologists and ophthalmologists, as well as state educators; and, be it further

RESOLVED, That, when appropriate, the Ohio State Medical Association introduce a similar resolution to the AMA with the purpose of having Ohio's task force develop a model for a national study; and, be it further

RESOLVED, That the results and findings of this task force be made available to the general public.

By official action, **the House voted to adopt Amended Resolution 38-89.**

AMENDED RESOLUTION NO. 39-89
The Harvard Resource-Based Relative Value Scale (RBRVS)

RESOLVED, That the Ohio State Medical Association prepare and forward a resolution to the American Medical Association (AMA) indicating support of the AMA's current position on the Harvard Resource-Based Relative Value Scale (RBRVS) as published in the AMA Board of Trustees Report AA (I-88).

By official action, **the House voted to adopt Amended Resolution No. 39-89.**

AMENDED RESOLUTION NO. 40-89
Resource-Based Relative Value Scale Geographic Differentials

RESOLVED, That the Ohio State Medical Association oppose inappropriate geographic payment variations in the Resource-Based Relative Value Scale.

By official action, **the House voted to adopt Amended Resolution No. 40-89.**

AMENDED RESOLUTION NO. 41-89
Nursing Home Rules

RESOLVED, That the Ohio State Medical Association urge the Ohio Department of Health to seek consultation and advice from OSMA in developing rules and regulations that affect medical care in the nursing home setting; and, be it further

RESOLVED, That the Ohio State Medical Association continue to monitor all legislative action affecting medical care in nursing homes and provide testimony and consultation; and, be it further

RESOLVED, That OSMA work with groups such as the American Association of Retired Persons (AARP), the Association of Ohio Philanthropic Homes for the Aging (AOPHA) and nursing associations for the purpose of developing mutually supported positions regarding medical care regulations in nursing homes; and, be it further

RESOLVED, That the OSMA urge the AMA to continue to monitor federal legislation and HCFA regulations which affect physicians involved in nursing home care and to provide testimony and information relevant to appropriate medical management of nursing home patients.

By official action, **the House voted to adopt Amended Resolution 41-89.**

AMENDED RESOLUTION NO. 42-89
OSMA Annual Meeting Meals

RESOLVED, That OSMA meeting planners make an effort to ensure that ~~all~~ meals served at its Annual Meeting ~~be~~ prepared in such a fashion as to conform as much as possible to the recommendations of the American Heart Association **BE AVAILABLE.**

By official action, **the House voted to amend Resolution No. 42-89, as indicated in capital letters with deletions as noted, and to refer it to the OSMA Council.**

RESOLUTION NO. 43-89
State Moratorium on Medical Waste Incinerators

RESOLVED, That the Ohio State Medical Association recommend to the Ohio State Legislature that there be a moratorium in the construction of medical waste incinerators until its potential effect on the environment has been fully evaluated and the

Environmental Protection Agency guarantees that the smokestacks be continuously monitored and inspection in the facility for compliance of state and federal guidelines be regularly performed; and, be it further

RESOLVED, That the Ohio State Medical Association recommend to the Ohio State Legislature and the Ohio Environmental Protection Agency that a certificate of need be established so that the needs of the state be appropriately met and discourage for profit medical waste disposal companies from using the state of Ohio as its center or regional center for medical waste incineration; and, be it further

RESOLVED, That the Ohio State Medical Association establish or assign to one of its committees the problems of medical waste so that concerned members may have access to most recent state and federal guidelines and be able to advise its community leaders on how to address the growing public concern on medical waste.

By official action, **the House adopted Resolution No. 43-89.**

AMENDED RESOLUTION NO. 44-89
Clarification of Reporting Procedures Regarding Violations of Medical Practices Act

RESOLVED, That the OSMA work with the Ohio State Medical Board to develop a more clear statement of the responsibility of individual licensees and the functional role of their professional associations or societies as regards the subjective mandatory reporting requirements as stated in the Ohio Revised Code Section 4731.224 (B).

By official action, **the House voted to adopt Amended Resolution No. 44-89.**

RESOLUTION NO. 45-89
Gender-neutral Language

RESOLVED, That the OSMA ask that the AMA develop a policy on the use of gender-neutral language by its members when they are speaking in an official capacity, and in its publications; and, be it further

RESOLVED, The OSMA develop a policy on the use of gender-neutral language by its members when they are speaking in an official capacity, and in its publications by June 1990.

By official action, **the House referred Resolution No. 45-89 to the OSMA Council.**

RESOLUTION NO. 46-89
State Funding of Medical Education

Resolution No. 46-89 was withdrawn by the sponsor.

AMENDED RESOLUTION NO. 47-89
Childcare Law Reform

RESOLVED, That the OSMA seek to reform current legislation governing family day care homes and day care centers to provide for mandatory periodic criminal and abuse records checks for all the staff of existing and applicant family day care homes and day care centers; and, be it further

RESOLVED, ~~That the OSMA MSS ask the OSMA to seek to reform evaluate current legislation governing family day care homes and day care centers, as defined by the state, to impose licensing and/or regulation on *all* such family day care homes and day care centers.~~ **THAT THE OSMA FORM A TASK FORCE TO STUDY CURRENT ISSUES IN CHILDCARE, FAMILY DAY CARE HOMES, AND DAY CARE CENTERS AND PREPARE RECOMMENDATIONS FOR OSMA CONSIDERATION.**

By official action, **the House voted to amend Amended Resolution No. 47-89, as indicated in capital letters with deletions as noted, and to adopt it as amended.**

RESOLUTION NO. 48-89
Protection for Peer Reviewers

RESOLVED, That Ohio State Medical Association seek legislation that protects physicians from professional liability while performing peer review in Ohio.

By official action, **the House referred Resolution No. 48-89 to the OSMA Council.**

RESOLUTION NO. 49-89
Opposition to MEEP

Resolution No. 49-89 was withdrawn by the sponsor.

RESOLUTION NO. 50-89
Financial Planning Advisory Committee

By official action, **the House rejected Resolution 50-89.**

REPORT A — 1989
Committee to Review OSMA House of Delegates Policy
POLICIES TO BE RETAINED — 1985 HOUSE OF DELEGATES PROCEEDINGS

5-85 Physician Reimbursement Methods
8-85 Unethical Aspects of Certain Medical Care Plans
19-85 Establishment of an Ohio State Medical Association Historian
23-85 Ohio Supreme Court Decisions Affecting Workers' Compensation and the Ability of an Employer to Dismiss an Employee
24-85 Professional Liability in OB/GYN
27-85 Medical Professional Liability
31-85 Professional Liability
34-85 Medical Liability as It Relates to Medical Students
36-85 Abortion Clinic Violence
41-85 Minimum Height of Road Vehicle Bumpers
42-85 Eye Prophylaxis in Newborns for Gonorrhea as Well as Mandatory Gonorrhea Cultures in Pregnancy
44-85 Media Advertising for Tobacco Products

45-85 Generic Drugs
48-85 Termination of Pregnancy Is Inconsistent with Natural Law
49-85 Ohio State Medical Board
50-85 Need for a Full-Time Medical Director of the OSMA Physician Effectiveness Program (PEP)
51-85 Promotion of Education on Alcoholism/Drug Abuse
52-85 Emergency Training for Safety Forces
53-85 Federal Excise Tax on Cigarettes
54-85 Federal Tobacco Subsidies
55-85 Non-Smoking Sections Within Public Eating Facilities
56-85 Alcohol-Impaired Driving
62-85 ABCs of Safe Driving

By official action, **the House voted to adopt Report A.**

AMENDED EMERGENCY RESOLUTION 02-89
News Media Access to New Scientific Developments

RESOLVED, That the OSMA request that the National Institutes of Health and the Food and Drug Administration mandate that all information developed in any clinical trials be first released to the medical and scientific communities prior to being released to the public; and, be it further

RESOLVED, That this resolution be forwarded to the AMA House of Delegates for its consideration.

By official action, **the House voted to adopt Amended Emergency Resolution No. 02-89.**

REPORT OF RESOLUTIONS COMMITTEE NO. 3

Raymond J. McMahon, Jr., MD, Stark County, Chairman, presented the report of Resolutions Committee No. 3. The House took action on the report as follows:

SUBSTITUTE RESOLUTION NO. 51-89
Prohibit Smoking and Use of Tobacco Products
(Replacing No. 51, 53 and 69)

RESOLVED, That the Ohio State Medical Association reaffirm its policy established by Substitute Resolution No. 35-86 (OSMA Support of a Tobacco-Free Society) and 58-87 (Smoke-Free Environment) with the addition of the following:

That OSMA urge its member physicians to prohibit smoking and use of tobacco products in any office space owned, leased or occupied by physicians;

~~That OSMA urge that smoking and use of tobacco products be prohibited in hospitals, other health care institutions and medical schools in Ohio;~~

THAT OSMA work toward legislation **AND POLICIES** to promote a ban on smoking and use of tobacco products in **HOSPITALS, HEALTH-CARE INSTITUTIONS AND** educational institutions **(INCLUDING MEDICAL SCHOOLS)**; and, be it further

RESOLVED, That a copy of this resolution be forwarded to the American Medical Association House of Delegates.

By official action, **the House voted to amend Resolution No. 51-89, as indicated in capital letters, with deletions as noted, and to adopt it as amended.**

RESOLUTION NO. 52-89
Education Regarding Prescribing Controlled Substances

RESOLVED, That the Ohio State Medical Association in cooperation with appropriate agencies develop and make available educational programs and information to ensure proper prescribing and dispensing of controlled substances.

By official action, **the House voted to adopt Resolution No. 52-89.**

RESOLUTION NO. 54-89
Waiting Period Before Gun Purchase

RESOLVED, That the Ohio State Medical Association go on record as supporting the concept of a waiting period of at least one week before purchasing any form of firearm in the state of Ohio; AND, BE IT FURTHER

RESOLVED, THAT THIS RESOLUTION BE PRESENTED TO THE AMA HOUSE OF DELEGATES AT THE JUNE, 1989 MEETING.

By official action, **the House voted to amend Resolution No. 54-89, as indicated in capital letters with deletions as noted, and to adopt it as amended.**

SUBSTITUTE RESOLUTION NO. 55-89
Biomedical Research
(Replacing No. 55 & 56)

RESOLVED, That the Ohio State Medical Association develop a program to educate the public regarding the benefits of the use of animals in biomedical research; and, be it further

RESOLVED, That the Ohio State Medical Association acknowledge its commitment to the humane treatment of animals used in biomedical research and the pursuit of alternative models for research, where appropriate; and, be it further

RESOLVED, That the Ohio State Medical Association undertake appropriate steps to influence public policy concerned with the use of animals in biomedical research in order to ensure the optimum environment for the creation of new knowledge to better diagnose, treat and prevent disease; and, be it further

RESOLVED, That the Ohio State Medical Association support legislation establishing a minimum criminal penalty of a felony, fourth class, for unauthorized removal of research animals and/or willful damage to research facilities and/or research projects; **AND, BE IT FURTHER**

RESOLVED, THAT THE OHIO STATE MEDICAL ASSOCIATION IMMEDIATELY ACT TO USE ITS INFLUENCE TO SUPPORT THE CONCEPT OF UNITED STATES SENATE BILL 727.

By official action, **the House voted to amend Substitute Resolution No. 55-89, as indicated in capital letters with deletions as noted, and to adopt it as amended.**

RESOLUTION NO. 57-89
Pharmaceutical Company Advertising

By official action, **the House voted to reject Resolution No. 57-89.**

SUBSTITUTE RESOLUTION NO. 58-89
Amend Good Samaritan Act
(Replacing Nos. 58 & 59)

RESOLVED, That the Ohio State Medical Association propose legislation to amend Section 2305.23 (Good Samaritan Statute) of the Ohio Revised Code to extend the statute to enable physicians, within hospitals, to provide emergency care to patients with whom they have no professional relationship~~,~~. ~~until the arrival of the hospital's regular resuscitation team or the patient's attending physician.~~

By official action, **the House voted to amend Substitute Resolution No. 58-89, as indicated in capital letters with deletions as noted, and to adopt it as amended.**

SUBSTITUTE RESOLUTION NO. 60-89
Anabolic Steroids
(Replacing No. 60 & 61)

RESOLVED, That the Ohio State Medical Association reaffirm its policy established by Council on March 26, 1988, to support prohibition of prescribing, dispensing or sale of anabolic steroids for improving athletic performance; and, be it further

RESOLVED, That OSMA actively support state legislation ~~introduced on May 1, 1989 by State Representative William Schuck~~ calling for a ban on prescribing, dispensing, selling and administering anabolic steroids and other related drugs for muscle building and enhancement of athletic performance — with severe penalties for those who ~~deal steroids or possess large amounts~~ **ARE FOUND GUILTY OF ILLEGAL POSSESSION OR DISTRIBUTION** of such drugs; and, be it further

RESOLVED, That the Joint Advisory Committee on Sports Medicine of OSMA, the Ohio High School Athletic Association and Ohio Athletic Trainers Association be urged to continue efforts, in cooperation with the Ohio Department of Education, to educate students, athletes, parents, physicians, coaches, athletic trainers and school administrators as to the harmful effects of anabolic steroids for improving athletic performance.

By official action, **the House voted to amend Substitute Resolution No. 60-89, as indicated in capital letters with deletions as noted, and to adopt it as amended.**

SUBSTITUTE RESOLUTION NO. 62-89
Care of the Chronically, Mentally Ill

RESOLVED, That the OSMA encourage improvement of Ohio's mental health system through evaluation of the admission criteria and conditions within the mental health system by a select panel of experts; and, be it further

RESOLVED, That the Ohio mental health system provide up-to-date psychiatric treatment to patients with acute and intermittent psychiatric conditions, as well as planning, evaluation and treatment for those with chronic psychiatric conditions; and, be it further

RESOLVED, That decisions concerning access to and treatment in the Ohio mental health system be made by ~~psychiatric~~ physicians.

By official action, **the House voted to amend Substitute Resolution 62-89, as indicated in capital letters with deletions as noted, and to adopt it as amended.**

RESOLUTION NO. 63-89
Mandatory Random Drug Testing in Competitive Sports

RESOLVED, That OSMA recommend to the Ohio High School Athletic Association that a mandatory random drug testing program be established as a requirement for participation in scholastic sports in Ohio; and, be it further

RESOLVED, That a companion resolution be forwarded to the AMA recommending that a similar program be established by the NCAA and professional leagues as a requirement for participation in collegiate and professional sports.

By official action, **the House voted to adopt Resolution No. 63-89.**

RESOLUTION NO. 64-89
Confidentiality of Drug Enforcement Agency Numbers

By official action, **the House voted to reject Resolution No. 64-89.**

RESOLUTION NO. 65-89
Drunk Driving

RESOLVED, That the Ohio State Medical Association go on record as advising and supporting legislation mandating immediate and automatic ~~confiscation~~ seizure of any owned or leased vehicle operated by a drunken driver.

By official action, **the House voted to amend Resolution No. 65-89, as indicated in capital letters with deletions as noted, and to adopt it as amended.**

SUBSTITUTE RESOLUTION NO. 66-89
Warning Label on Personal Listening Devices

RESOLVED, That OSMA support legislation requiring all

manufacturers of personal listening devices with earphone speakers to label their products with "MAY BE DANGEROUS TO YOUR HEARING" in an easily recognizable location; and, be it further

RESOLVED, That this issue be presented to the AMA for similar action.

By official action, **the House voted to adopt Substitute Resolution No. 66-89.**

RESOLUTION NO. 67-89
Physicians' Assistants

By official action, **the House voted to reject Resolution No. 67-89.**

AMENDED RESOLUTION NO. 68-89
Ohio State Medical Board

RESOLVED, That the Ohio State Medical Association support any reasonable efforts, legislatively or otherwise, aimed at strengthening the budgetary needs of the Ohio State Medical Board by allocating a greater share of *current* physician licensure fees to that end; and, **be it further**

RESOLVED, that the position of OSMA Council established on March 18, 1989 recommending that the proposed increase of $60 in the physician biennial reregistration fees in the 1990-91 state budget be allocated to the Ohio State Medical Board be reaffirmed; and, be it further

RESOLVED, that the OSMA recommend that one-hundred percent (100%) of all future increases in licensure fees be allocated to the Ohio State Medical Board.

By official action, **the House voted to adopt Amended Resolution No. 68-89.**

AMENDED RESOLUTION NO. 70-89
Call the Doctor

RESOLVED, That OSMA encourage establishment of "Call the Doctor Programs" by as many county medical societies and/or medical staffs as possible.

By official action, **the House voted to adopt Amended Resolution No. 70-89.**

RESOLUTION NO. 71-89
Ohio Medical Hall of Fame

RESOLVED, That the House of Delegates of OSMA instruct Council to establish an ad hoc committee or a task force for the purpose of studying, evaluating and reporting at the next annual convention on the possibility of establishing an Ohio Medical Hall of Fame.

By official action, **the House voted to adopt Resolution No. 71-89.**

RESOLUTION NO. 72-89
Facilitating Communication — 1 800 WATTS

By official action, **the House voted to reject Resolution No. 72-89.**

SUBSTITUTE EMERGENCY RESOLUTION NO. 05-89
AIDS Legislation

RESOLVED, That the Ohio State Medical Association reaffirm its policy of support for ~~the~~ **THOSE** provisions of Senate Bill 2 as voted out of the Ohio Senate Health and Human Services Committee on April 12, 1989, which are consistent with the Ohio State Medical Association's Substitute Resolution 54-88; and, be it further

RESOLVED, That the Ohio State Medical Association continue to seek changes in Senate Bill 2 consistent with the Ohio State Medical Association's Substitute Resolution 54-88 and, be it further

RESOLVED, That the Ohio State Medical Association supports the **INCLUSION OF THE** following provisions: ~~contained in Senate Bill 2:~~

1) confidential and anonymous testing and reporting of all seropositive HIV-infected individuals to departments of health with a documented program of partner notification; **AND THE ANONYMOUS TESTING PROGRAM BE RE-EVALUATED IN ONE YEAR'S TIME AS TO ITS EFFICACY AS AN EPIDEMIOLOGIC PROGRAM ACCOMPANIED BY PERIODIC PUBLIC REPORTS FROM THE ANONYMOUS TESTING SITES;**
2) the recognition of HIV infection as a reportable infectious disease;
3) require appropriate informed consent procedures for HIV testing;
4) ~~the inclusion of anonymous testing sites to encourage individuals to be tested to determine their HIV status;~~ **THAT THE OHIO STATE MEDICAL ASSOCIATION SUPPORT PROTECTION AGAINST UNREASONABLE DISCRIMINATION IN EMPLOYMENT, BUT CONTAGIOUS DISEASES PER SE ARE NOT TO BE INCLUDED AS A HANDICAP UNDER OHIO LAW;**
5) ~~inclusion of a provision in Ohio's handicap law that conforms the treatment of infectious diseases to section 504 of the United States Rehabilitation Act of 1973;~~
65) ~~create a procedure to permit~~ **ALLOW** a health-care worker, who may have come in contact with bodily fluids of a person, whom the health-care worker has reason to believe may be HIV-infected, to require **WITHOUT COURT INTERVENTION** having that individual **CONFIDENTIALLY** tested to determine if HIV infection is present.

By official action, **the House voted to amend Substitute Emergency Resolution No. 05-89, as indicated in capital letters with deletions as noted, and to adopt it as amended.**

SUBSTITUTE EMERGENCY RESOLUTION NO. 06-89
HIV Infection

RESOLVED, That the Ohio State Medical Association request the governor of Ohio, the Ohio General Assembly, and the director of public health to require that HIV infection be added to the list of reportable, infectious or communicable diseases and to institute at that same time a formal, documented program of partner identification and notification for cases of HIV infection in order to constrain the further spread of this disease, in accordance with appropriate public health policy as adopted in the Ohio State Medical Association Substitute Resolution 54-88.

By official action, **the House voted to adopt Substitute Emergency Resolution No. 06-89.**

PRESIDENT'S ADDRESS

President Baumgartner discussed the current state of the profession, the direction in which it appears to be headed, and what can and should be done to set a proper course.

He emphasized that for physicians, meeting patients' needs must be foremost — but that those needs must be balanced with government and third-party regulations, hospital demands, competition and utilization rules. This delicate balancing act, in President Baumgartner's opinion, has triggered a growing and very deep disillusionment with the practice of medicine.

In spite of gloom and doom, and the urge to throw open the window and shout, "I'm madder than hell and I'm not going to take it anymore," President Baumgartner declared that *first and foremost we must remain united.* We must agree to discuss, argue, attempt to persuade, decide and accept a decision, and pull together. Divide-and-conquer methods have been most successful in other counties including Great Britain, France, West Germany and Canada.

We must remain the patient advocate in protecting the physician-patient relationship, he said. He also recommended the following:

- We must make a serious and persistent effort to counter the insidious and growing diversion and deceit in terminology. For example, "medically unnecessary service" should be properly branded as "uncovered service." Terms such as "managed health care," "expenditure targets" and "assignment of resources" must be clearly and immediately identified as simple euphemisms for *rationing.*
- We must combat the increasing publicity over increased health-care costs. We must point out the alternatives — *a return to lesser services or outright rationing of care.*
- We need to promote the entire health industry and team up with hospitals and insurers to point out that the health industry is a major employer, and that the wages paid are returned to the economy. This industry does not export, has no real pollution problem and works literally 24 hours per day to promote the health of citizens.
- We must tell the public more of what we do. There should be more public awareness of outstanding efforts such as Project OPEN. The indigent care and uncompensated care provided by the entire industry must be publicized repeatedly.
- We cannot have universal coverage of all health care without accepting the costs. We have reached the limits of cost-shifting. If there is to be rationing, make that a conscious public decision and policy. Don't force physicians and hospitals to make such decisions.

President Baumgartner re-emphasized that medicine must face monumental challenges squarely in order to preserve the level of care and make progress. He cited the tremendous satisfaction for a physician when severely injured or ill patients recover and return to a meaningful and productive life.

In conclusion, he reminded the delegates that the practice of medicine is still an honor and privilege. All of the many problems are worth the effort to preserve the most noble of the professions.

The House accepted the report by acclamation and it was filed.

The report of Resolutions Committee No. 3, as a whole, as amended, was approved by the House.

INAUGURAL CEREMONY

Herman I. Abromowitz, MD, escorted Mrs. Marshall and the Marshall's daughter to the rostrum.

Dr. Irons administered the presidential oath of office to Dr. Marshall. Dr. Baumgartner then presented to Dr. Marshall the official gavel and the president's medallion.

Mrs. Baumgartner was escorted to the rostrum by Dr. Henry Krueger.

Dr. Marshall presented to Dr. Baumgartner the past president's pin, the president's plaque and a replica of the president's medallion to both Dr. Baumgartner and Mrs. Baumgartner.

Dr. Marshall then briefly addressed the House. His remarks were followed by a standing ovation.

The meeting was turned over to Dr. Baumgartner who thanked the OSMA Council, the House and the OSMA staff for their support during his year as president. Dr. and Mrs. Baumgartner received a standing ovation.

There being no further business, the House of Delegates adjourned.

AIM HIGH

AIR FORCE MEDICINE— AN ATTRACTIVE ALTERNATIVE TO PRIVATE PRACTICE.

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AIR FORCE

Gauguin . . . *continued*

earlier than did Gauguin.

Gauguin returned to France in 1893 for treatment of his poor medical condition. The following year he was involved in a brawl outside a bar in Brittany, where he received a fracture of the right leg above the ankle, which was so severe that the bone protruded.[2] This leg gave him trouble for the rest of his life. In 1895, he acquired a diffuse skin eruption, which he thought was due to syphilis. Although this is possible, description of the problem available today is too meager to tell us very much. That same year, he returned to Tahiti. His leg continued to torment him, and he was not able to bear weight on it. The pain became so severe that at times he resorted to oral laudanum and even injections of morphine. The skin eruption became chronic. Tahitians became convinced that he suffered from syphilis and leprosy and avoided him for obvious reasons.

In "The Moon and Sixpence," which is loosely based on the life of Gauguin, Somerset Maugham, the physician and author, perpetuated the unsubstantiated diagnosis of leprosy. Even Gauguin's eyes developed problems. A lingering bilateral conjunctivitis prevented him from painting. He required glasses for near vision. His last self-portrait, which is in the Kunstmuseum in Basel, shows him wearing corrective lenses.

Heart trouble, dyspnea, hemoptysis, eye problems, chronic suppurating dermatitis and severe leg pains were more than his psyche could withstand. On the eve of the new year of 1898, Gauguin climbed a hill into the Tahitian wilderness, swallowed a box of arsenic powder in a suicide attempt, and briefly fell asleep. He awoke, vomited, but was too weak to move out of the sun. The dose of arsenic retained was not lethal, and he staggered home the following day. His leg, skin, lungs and heart continued to torture him until his death in the Marquesa Islands in 1903.

Despite these tribulations, Gauguin persevered as an artist. Whenever his suffering relented, he would paint vigorously. His paintings show the bright colors of the tropics. They are clearly and simply composed like primitive art. The compositions are rather flat and details are few. Through these techniques of simplifying the composition, Gauguin created a powerful style.

Gauguin sacrificed a comfortable middle class life to pursue his artistic career. He was an outcast from French society who never fit into native society in the South Pacific. His health became chronically poor. But Gauguin did achieve his goal. He created a form of romantic art that profoundly influenced a generation of artists. Picasso, Matisse, Munch and the German Expressionists all acknowledged their debt to him. **OSMA**

Developing and Maintaining Uniformity in the CME Site-Survey Process, Part II

By Albert N. May, MD

Editor's Note: *This concludes Dr. May's report on Continuing Medical Education. Part I appeared in the June issue of* **OHIO Medicine.**

ESSENTIAL 5 — Evaluation:

1. **Copies of instruments used.**
2. **Summary reports with findings.**
3. **CME Committee minutes,** showing annual review of the CME program, utilizing the Mission Statement as a criterion as well as review of CME activities provided. Other areas that can be evaluated in the CME Committee minutes include:
   — Have learning objectives been achieved;
   — What is the instructional quality of the CME activities;
   — What, if any, impact have the activities had on physician practice;
   — Are evaluations appropriate;
   — Are these evaluations used in future planning of both the CME activities as well as the improvement of the entire Continuing Medical Education program for the institution.
4. **Evaluation forms,** which address evaluation of the CME activity, achievement of learning objectives, quality of instruction, impact of the CME activity, achievement of learning objectives, quality of instruction, impact of the CME activity on the practicing physician, whether appropriate evaluation methods were used, and generation of data to be used in planning future CME activities.
5. **CME activity planning forms,** showing how findings are used in the planning process.
6. **Communications from the institution's administration,** including reactions to periodic reports from the Continuing Medical Education Committee/Director of Continuing Medical Education concerning the status of Continuing Medical Education.
7. **Staff surveys,** evaluating CME activities, quality of instruction and impact/effectiveness of the activity.
8. **Surveillance Committee,** evaluating achievement of Learning Objectives, quality of instruction as well as impact of the CME activity in respect to answering the identified need which gave rise to the activity in the first place.
9. **Minutes of the Governing Board,** showing reception and discussion relating to periodic reports on the Continuing Medical Education program of the institution from the Continuing Medical Education Committee.
10. **Medical Executive Committee minutes,** showing periodic evaluation of the Continuing Medical Education program.

ESSENTIAL 6 — Management and Administration:

1. **Copy of audited financial report.**
2. **CME Committee minutes** showing continuity of the program planning and leadership as well as internal control and effective resource utilization on behalf of Continuing Medical Education.
3. **Evaluation forms,** showing that competent faculty and adequate facilities are employed and that there is internal control with efficient utilization of resources on behalf of the Continuing Medical Education program.
4. **CME activity planning forms** demonstrating competent faculty and the utilization of an adequate record-keeping system.
5. **Data derived by the CME accreditation site surveyors,** showing continuity of CME leadership, effective use of resources with controls, the presence of a budget, adequate facilities and a working record-keeping system.
6. **Information from the institution's administration,** relating to the job description of the Director of Continuing Medical Education, staff support, continuity of CME leadership, internal control/resource utilization and the presence of an adequate budget.
7. **An institutional Table of Organization** which identifies the administration and authorities for the Director of Continuing Medical Education as well as the Continuing Medical Education Committee, staff support and suggests that the staff present is/is not appropriate for the Continuing Medical Education operation.
8. **Staff surveys,** commenting on competent faculty.
9. **Director of Continuing Medical Education correspondence,** relating to competency of faculty.
10. Minutes of the Governing Board, relating to internal control and resource utilization on behalf of the Continuing Medical Education program.
11. **Minutes of the Medical Executive Committee,** relating to the Table of Organization for the Continuing Medical Education planning unit as well as providing for continuity of leadership in the Continuing Medical Education program.

ESSENTIAL 7 — Joint Sponsorship:

1. **Forms used to document process.**
2. **Letters used to communicate with prospective joint sponsors.**
3. **CME Committee minutes,** identifying the entire planning and evaluation process of the jointly-sponsored CME activity.
4. **Evaluation forms,** relating to the jointly-sponsored activity.
5. **CME activity planning forms,** relating to the jointly-sponsored activity from the viewpoint of the accredited sponsor's involvement in planning and evaluation.
6. **Information gathered by the site surveyors,** relating to appropriateness of joint sponsorship activities.
7. **The Mission Statement,** relating to whether the CME program sees joint sponsorship as part of its outreach Continuing Medical Education activities.

The documentation presented above as it relates to each specific ESSENTIAL can be arranged in another useful manner, i.e., according to source.

THE CONTINUING MEDICAL EDUCATION COMMITTEE MINUTES throughout the period of a year may well have comments clarifying:

1. **ESSENTIAL 1 (the Mission Statement):** the scope of the CME effort, the audience for whom Continuing Medical Education activities are being planned, as well as the types of activities which may be planned.
2. **ESSENTIAL 2 (Needs Assessment):** the relationship of CME content with Needs Assessment and assuring that faculty members understand what the educational needs of the participant-physician group are.
3. **ESSENTIAL 3 (Objectives):** showing the relationship of the formulation of Learning Objectives with Needs Assessment, that each CME activity has Learning Objectives and that the content of the CME activity is appropriate for the physician-student group.
4. **ESSENTIAL 4 (Education Design):** showing the depth of educational planning and that the CME content is appropriate to the physician-student body and that appropriate educational methods are employed and that there is adequate time for faculty/physician-student interaction.
5. **ESSENTIAL 5 (Evaluation):** indicating periodic review of the entire CME program as well as individual activities in relationship to whether Learning Objectives were achieved, and evaluation of the quality of instruction as well as the impact of the CME activity on physician practice, whether evaluation methods were appropriate and that such evaluations are used in future CME activity planning.
6. **ESSENTIAL 6 (Administration/Resources):** showing continuity of the CME leadership as well as internal control and effective resource utilization on behalf

of the CME program.

7. **ESSENTIAL 7 (Joint Sponsorship):** showing integral involvement in the development and evaluation of jointly-sponsored Continuing Medical Education activities.

CME ACTIVITY PLANNING FORMS can document:

1. **ESSENTIAL 1 (Mission Statement):** defining the audience for which the CME activities are being planned as well as formats of programs and general types of education strategies.
2. **ESSENTIAL 2 (Needs Assessment):** listing the method of Needs Assessment for each CME activity as well as relating the educational content with the Needs Assessment and assuring that the faculty understands the physician-student group needs.
3. **ESSENTIAL 3 (Objectives):** assuring that each CME activity has Learning Objectives and that these are related to the Needs Assessment and are made available to prospective students.
4. **ESSENTIAL 4 (Education Design):** relating to the educational planning process as well as the educational format for the CME activity utilizing appropriate methods and assuring specific time for faculty/physician-student interaction.
5. **ESSENTIAL 5 (Evaluation):** showing that data derived from CME activity evaluations are used in future CME planning.
6. **ESSENTIAL 6 (Administration/Resources):** showing that competent faculty is used and that adequate records are maintained.
7. **ESSENTIAL 7 (Joint Sponsorship):** showing the integral involvement of CME planning unit with the non-accredited CME activity sponsor in jointly-sponsored programs.

EVALUATION FORMS can develop data on:

1. **ESSENTIAL 2 (Needs Assessment):** showing that CME activity content is consistent with the Needs Assessment.
2. **ESSENTIAL 3 (Objectives):** showing that a positive relationship exists between the development of Learning Objectives and the Needs Assessment process and that each CME activity has Learning Objectives and that these are made available to prospective physician-students.
3. **ESSENTIAL 4 (Education Design):** indicating the educational planning and methods are consistent and that there is a time for faculty/physician-student interchange.
4. **ESSENTIAL 5 (Evaluation):** providing information of evaluation of CME activities, whether Learning Objectives have been achieved, the quality of instruction, impact of the activity on the practicing physician, whether appropriate evaluation methods have been employed, and whether these are used in future planning.
5. **ESSENTIAL 6 (Administration/Resources):** showing internal control and effective utilization of resources on behalf of the CME program as well as the utilization of competent faculty and appropriate facilities.
6. **ESSENTIAL 7 (Joint Sponsorship):** relating to the evaluation of jointly-sponsored activities.

DATA OBTAINED FROM OBSERVATION BY SITE SURVEYORS:

1. **ESSENTIAL 3 (Objectives):** comparison of Learning Objectives with stated educational needs.
2. **ESSENTIAL 4 (Education Design):** opportunity for faculty and physician-student interaction during the course of a CME activity.
3. **ESSENTIAL 6 (Administration/Resources):** including observations on the working relationships between the Director of Continuing Medical Education, the support staff, the institution's administration, the medical staff with clearly stipulated responsibilities and authorities; description of the quality and quantity of support staff in relationship to the Continuing Medical Education program, continuity of CME leadership, the effective use of resources with controls on behalf of the CME program, adequacy of budget, facilities and record-keeping.
4. **ESSENTIAL 7 (Joint Sponsorship):** description of joint sponsorship mechanisms and process, if relevant.

PRE-CME PUBLICITY, INCLUDING FLIERS, BROCHURES, ANNOUNCEMENTS can include information on:

1. **ESSENTIAL 1 (Mission Statement):** including the nature of the physician-student audience, and types of educational activities to be provided.
2. **ESSENTIAL 2 (Needs Assessment):** including the educational content of the prospective CME activity and its relationship to the intended physician-student group's needs.
3. **ESSENTIAL 3 (Objectives):** including the relationship of stated Learning Objectives with the Needs Assessment, each educational activity having stated Learning Objectives

which are made available to prospective physician-students and a description that the CME activity content is appropriate for the designated physician-student group.

4. **ESSENTIAL 4 (Education Design):** including information that the educational format is appropriate to the intended physician-student group, utilizing appropriate educational methods and allowing for appropriate time for physician-student/faculty interaction.

DOCUMENTATION MAINTAINED BY THE INSTITUTION'S ADMINISTRATION may contain information on:

1. **ESSENTIAL 1 (Mission Statement):** including a memorandum of agreement identifying the Continuing Medical Education Committee, the Director of Continuing Medical Education and budget, as well as the job description, goals and objectives as they apply to the Director of Continuing Medical Education.
2. **ESSENTIAL 2 (Needs Assessment):** including Needs Assessment data for CME activity planning from the perspective of the institution's administration.
3. **ESSENTIAL 5 (Evaluation):** including periodic evaluations of the institutional CME program.
4. **ESSENTIAL 6 (Administration/Resources):** including job description for the Director of Continuing Medical Education, an adequate budget to assure staff support, establishment of internal control mechanisms for appropriate resource utilization on behalf of the Continuing Medical Education program, and commitment to the continuity of the CME program as well as its leadership.
5. **The Table of Organization** deals primarily with ESSENTIAL 6, describing administrative lines of authority, staff support and an indication that the staff is appropriate for the size of the Continuing Medical Education program.

MEDICAL STAFF SURVEY/QUESTIONNAIRES can provide documentation on:

1. **ESSENTIAL 1 (Mission Statement):** the nature of the target physician-student audience.
2. **ESSENTIAL 2 (Needs Assessment):** development of both subjective and objective educational needs as well as describing appropriateness of educational content with previously stated needs.
3. **ESSENTIAL 4 (Education Design):** impacting on the process of educational planning (requests for "hands-on" types of educational activities, etc.).
4. **ESSENTIAL 5 (Evaluation):** including evaluation of the educational activity, quality of instruction and its impact/effectiveness on physician activities.
5. **ESSENTIAL 6 (Administration/Resources):** relating to the utilization of competent faculty.

THE MISSION STATEMENT CAN DOCUMENT:

1. Date of approval/review by the governing body.
2. The geographic area served by the institutional CME program (local/regional).
3. Whether the CME program will be conducted all on-site or have an outreach component of programming.
4. The scope of the institutional CME effort.
5. The nature of the audience to be served.
6. The nature of the educational activities to be employed.

DATA FROM INSTITUTIONAL SURVEILLANCE COMMITTEES (Quality Assurance, Utilization Review, Morbidity and Mortality, etc.) can include documentation on:

1. **ESSENTIAL 2 (Needs Assessment):** in developing appropriate Continuing Medical Education activities which are problem-oriented and solution-seeking.
2. **ESSENTIAL 4 (Education Design):** related to the education planning process.
3. **ESSENTIAL 5 (Evaluation):** relating to the achievement of Learning Objectives, quality of instruction and an evaluation of the impact of the Continuing Medical Education program on participant-physicians.

CORRESPONDENCE OF THE DIRECTOR OF CONTINUING MEDICAL EDUCATION can include documentation that:

1. **ESSENTIAL 2 (Needs Assessment):** the faculty understands the needs of the physician-student group.
2. **ESSENTIAL 4 (Education Design):** that the educational methods are appropriate to the Learning Objectives and Needs Assessment and that there is sufficient time allotted for discussion between the faculty and physician-student group.
3. **ESSENTIAL 6 (Administration/Resources):** that competent faculty has been employed.

ATTENDANCE STATISTICS can document:

1. **ESSENTIAL 1 (Mission Statement):** the scope of effort of the Continuing Medical Education program as well as the variety of educational types of CME activities

(intramural versus extramural activities).

2. **ESSENTIAL 4 (Education Design):** suggesting appropriateness of teaching methods.

MINUTES OF THE GOVERNING BOARD CAN HELP SUBSTANTIATE:

1. **ESSENTIAL 1 (Mission Statement):** periodic review, update and acquiescence of the Mission Statement.
2. **ESSENTIAL 5 (Evaluation):** reaction to periodic Continuing Medical Education Committee reports on the state of the institutional CME program.
3. **ESSENTIAL 6 (Administration/Resources):** documenting CME administration continuity as well as internal budgetary controls for the adequate utilization of resources on behalf of the Continuing Medical Education program.

MINUTES OF THE MEDICAL STAFF EXECUTIVE COMMITTEE can document:

1. **ESSENTIAL 1 (Mission Statement):** identifying the scope of the CME program (the Continuing Medical Education Committee, Director of Continuing Medical Education, budget, bylaws) as well as the intended audience.
2. **ESSENTIAL 5 (Evaluation):** annual evaluation of the institutional CME program.
3. **ESSENTIAL 6 (Administration/Resources):** relating to the Table of Organization for the Continuing Medical Education planning unit as well as commitment for continuity in CME Committee leadership.

DEPARTMENTAL MINUTES can help document:

1. **ESSENTIAL 2 (Needs**

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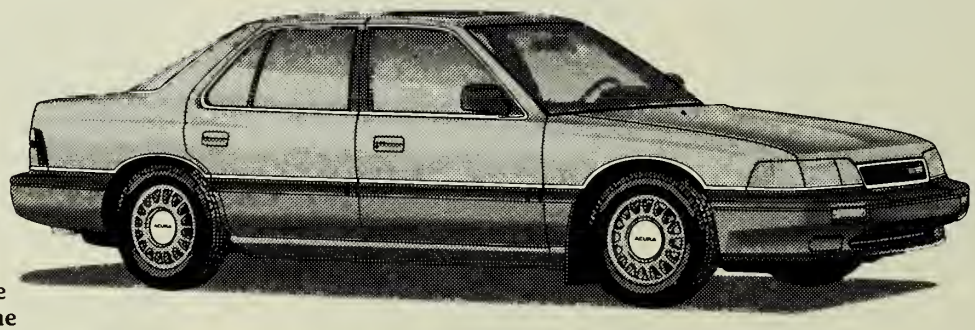

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Assessment): Needs Assessment process.

2. **ESSENTIAL 5 (Evaluation):** relating to evaluation of specific Continuing Medical Education activities as well as the general institutional CME program.

Summary of Report

Recognition of the inter-relationship which exists between and among the ESSENTIALS and, utilization of this knowledge as the prime focus in the examination of documentation maintained by the CME provider relative to its overall program and its component parts, constitute a means of ensuring uniformity and consistency in the CME site survey process, which is primarily criterion-referenced as opposed to value-judgment based.

References

1. *ESSENTIALS & GUIDELINES FOR ACCREDITATION OF SPONSORS OF CONTINUING MEDICAL EDUCATION.*
2. *ACCME Protocol for the Recognition of State Medical Societies to Accredit Intrastate CME Sponsors*
3. *Carl Spragg, MD, former Chairman of the OSMA Accreditation Committee, personal communication*
4. *Recommended documentation to be available for review by survey team*
5. *Checklist for required documentation*
6. *Site Survey Questions (ACCME)*

Albert N. May, MD is Chairman of the OSMA Committee on Education, and a member of the OSMA Committee on Accreditation.

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1. Data on file, Lilly Research Laboratories.

Additional information available to the profession on request.

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Brief Summary • Consult the package literature for complete information.

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients at a reduced dosage of 150 mg h.s. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General* — 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizabdine is similar to that in normal subjects.

Laboratory Tests — False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

Drug Interactions — No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system, therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility — A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy — Teratogenic Effects — Pregnancy Category C — Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers — Studies conducted in lactating women have shown that < 0.1% of the administered oral dose of nizabdine is secreted in human milk in proportion to plasma concentrations. Caution should be exercised when administering nizatidine to a nursing mother.

Pediatric Use — Safety and effectiveness in children have not been established.

Use in Elderly Patients — Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizabdine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among reported adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs < 0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic — Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L) and, in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular — In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS — Rare cases of reversible mental confusion have been reported.

Endocrine — Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic — Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental — Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity — As with other H_2-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been reported. Because cross-sensitivity in this class of compounds has been observed, H_2-receptor antagonists should not be administered to individuals with a history of previous hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other — Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported.

Overdosage: Overdoses of Axid have been reported rarely. The following is provided to serve as a guide should such an overdose be encountered.

Signs and Symptoms — There is little clinical experience with overdosage of Axid in humans. Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

Treatment — To obtain up-to-date information about the treatment of overdose, a good resource is your certified regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the *Physicians' Desk Reference (PDR)*. In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient.

If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance.

PV 2096 AMP [013089]

Paul Gauguin

By James G. Ravin, MD

Paul Gauguin was a leading French painter of the post-impressionist period. He spent six years as a sailor and 12 years as a stockbroker before devoting himself fully to art. He began painting in his mid-20s, rather late for a successful artist.

At the age of 35 Gauguin (1843-1903) decided to abandon the successful, secure life of a stockbroker for an unknown future as a full-time artist. This created a family crisis, since he had a wife and several children, but no other source of income. Except for the artist, the Gauguin family moved from Paris to Copenhagen, to live with his wife's parents. His inlaws were not sympathetic to his artistic aspirations and the marriage failed. Gauguin returned to Paris penniless and unhappy, but determined to give up everything for art.

In 1887, Gauguin left France for Panama. His aim was to find a place that was inexpensive, quiet and far from the cold winters of Paris, where he could paint at leisure. He had fond memories of voyages to South America from having traveled there as a mate's apprentice when he was between 17 and 19 years of age. In addition, his sister had married a Columbian shopkeeper who sold goods to men engaged in digging the Panama Canal. Gauguin traveled to Panama with another artist, Charles Laval, who suffered from tuberculosis.[1] The two were soon disillusioned by the difficulties of life on the isthmus, particularly without any money. Gauguin took a job working 12 hours a day digging the canal, but was let go two weeks later when the canal company was in financial difficulty. He contracted yellow fever and dysentery in Panama, while the tubercular Laval fared even worse. They moved on to the French island of Martinique for four months, then returned to France in order to obtain medical care.

There Gauguin met Vincent van Gogh, who had similar artistic ideas. Van Gogh suggested that they live and paint together. They tried for a few weeks but the attempt was a tragic failure. Their personalities clashed gratingly. Van Gogh threatened Gauguin with a razor, and Gauguin moved out. Soon afterward, Van Gogh mutilated his own ear.

Gauguin decided to leave Europe again, this time for the South Pacific. He thought that industrial society forced men to dedicate their lives toward materialistic goals, a coercion that was antagonistic to the emotions of an artist. He went to Tahiti to learn from the natives. He thought Tahiti would be an innocent paradise like the Garden of Eden. Gauguin did not know that the cost of living in Papeete, the main town of Tahiti, was higher than that in Paris. He was influenced by travelogues that described the South Pacific as a paradise, and was not aware that the Pacific area was actually one of the world's most unhealthy places to live. Malaria, intestinal disease, tuberculosis, syphilis and gonorrhea are still major problems there today, as they were in Gauguin's time.

Moving to the South Pacific was radical 90 years ago, although it does not seem revolutionary today. Before Gauguin, few Europeans had actually gone to live in primitive societies to learn from the natives. The Europeans who had gone abroad were usually colonials, in commerce, or missionaries. Unlike Gauguin, most Europeans thought that their role in underdeveloped societies was to teach the natives Western standards. In Kipling's words, this was "the white man's burden."

Gauguin traveled to Tahiti in 1891 at age 43. He was solidly built, had a slight suntan, chestnut brown hair, blue eyes and an imperial beard. Soon after his arrival, he suffered from heart trouble and repeated hemoptysis, coughing up half a pint of blood a day. He was treated at the military hospital in Tahiti with mustard plasters and cupping of the chest. In his notes, Gauguin never gave the diagnosis of his doctors. In view of Gauguin's liberal lifestyle, the customary assumptive diagnosis has been syphilis. However, considering his association with Laval, who had advanced tuberculosis, Gauguin's recurrent episodes of hemoptysis, and high prevalence of tuberculosis in the 19th century, a diagnosis of tuberculosis would also seem plausible. Gauguin's history is reminiscent of that of Robert Louis Stevenson, who was tubercular, and who traveled to Tahiti and other islands in the South Pacific just a few years

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COUNTY COLLECTION

County medical societies rate the OSMA

Editor's note:

How well do Ohio's local county medical societies relate to the Ohio State Medical Association? How well do county societies relate to their communities? And, finally, what steps could the OSMA take to keep county medical societies better informed of OSMA activities and what's happening in medicine?

Late last year, the OSMA's Department of Communications sent a survey to county medical society presidents and executive directors which asked all of these questions. Fifty of the 86 county medical presidents responded, as did 14 of the 28 county executives. We thought you might be interested in the results, so we have printed their combined responses below.

COUNTY MEDICAL SOCIETY SURVEY

Section One: SOCIETY'S RELATIONSHIP WITH THE OSMA

1. How would you characterize your society's contact with the OSMA?

Society Executives	County Presidents	
1	15	seldom communicate
4	19	communicate when major problems arise
9	15	communicate often

2. How would you describe the responsiveness of the OSMA when you have asked for assistance?

	1	not very responsive
	12	fairly responsive
14	37	very responsive

3. Has your Councilor attended a county medical society meeting in the last three months?

9	26	Yes
3	9	No
2	14	Hasn't been invited

4. Has an OSMA staffperson attended a county society meeting in the last three months?

9	18	Yes
2	13	No
2	18	Hasn't been invited

County Collection . . .

County medical society survey . . . *continued*

5. To your knowledge, in the past year has your society utilized the following OSMA services?

	Yes		No		Don't Know	
Service	**Executives**	**Presidents**	**Executives**	**Presidents**	**Executives**	**Presidents**
Legal	10	30	2	17	1	3
Legislative	12	28	1	17		4
Communications	10	25	4	21		3
Ombudsman	10	24	1	21	2	4
Membership	11	18	2	22	1	8
CME	6	13	5	30		6
Development	4	5	7	34		8
CMS Relations	10	20		24		5

6. How often do you read the following OSMA publications?

	Always		Usually		Seldom		Never	
Publication	**Executives**	**Presidents**	**Executives**	**Presidents**	**Executives**	**Presidents**	**Executives**	**Presidents**
a. *OHIO Medicine*	8	21	3	21	2	6	1	2
b. *The OSMAgram*	10	28	2	24	1	2	1	1
c. *Legislative Bulletin*	7	25	3	20	3	4	3	1
d. *Medical Staff Bulletin* (posted in hospitals)	5	12	4	16	4	17	1	5
e. Council Reports (sent to CMS President after each Council meeting)	8	22	2	19	3	6	1	2

7. What steps could the OSMA take to keep you better informed of OSMA activities and what's happening in medicine?

Executives:
"The amount and quality of information generated by the OSMA staff is such that there is very little, if anything, that could be added, changed or deleted. The regular execs meetings fill in any gaps that may exist. Assist with local informational meetings and selected topics symposiums."
"I have found physicians respond best to short bursts of information. A series of brief fact sheets highlighting specific areas of cancer, i.e. legislation alerts, currently provide more detail than the docs are willing to absorb and respond to — I've talked with Bob Clinger and Kent Studebaker regarding changing the alert format — I think a better physician response would be forthcoming with these changes."

Presidents:
"General help to me and presidents of smaller county societies — on what we can and should be trying to do at a county level."
"More visible locally. Staff members at some meetings on a regular basis, i.e. once a year or twice a year. Doing a good job now."
"Hospital medical staff becomes an important area of physician information source, involve executives and hospital clinical staff in an important communication channel between OSMA and its members."

8. Do you have any suggestions or have you heard members make suggestions regarding services or benefits the OSMA could add to make membership in the association more attractive?

Executives:
"Our board has talked about forming a coalition of small neighboring counties to provide benefits such as car leasing or travel. Our society is so small there is no way to make a profit. We would have approximately 50 physicians who MIGHT use such a benefit and perhaps 5-10 who would — hardly worth the effort as far as non-dues revenue is concerned."
"Those who contact OSMA or attend OSMA functions appreciate the work and service of OSMA — however, if the member has no direct exposure to OSMA, they often do not utilize or value the services."

Presidents:
"Members want more OSMA involvement in political process interfering in the practice of medicine such as Medicare reimbursement and regulations; PPOs and third-party payors causing unnecessary interventions in practice. Better input from OSMA to legislators. Membership survey of issues."
"I am presently asking members about the services they would need. We probably will need help and direction from OSMA concerning implementing new programs."
"It would give more strength to the OSMA if OSMA became more involved with everyday physicians' affairs (e.g. carrying physicians' insurance, hospital privileges, running their office, personnel, billing, etc.) In general, OSMA needs to show more strength in political power in order to attract new members. Have you thought about having a hand in Board exam or Board-certification?"
"The membership would like definite and very strong stands from OSMA on issues with third-party payors; hospital encroachment on physicians' practices and their ability to make hospital decisions without physician input; curb on ability of PSRO to give summary sanctions, etc."

Section Two: SOCIETY'S RELATIONSHIP WITH THE COMMUNITY

1. How would you characterize your society's involvement with the local community?

Society Executives	County Presidents	
5	10	Very involved
6	16	Somewhat involved
2	23	Not very involved

2. Is your society involved in any of the following types of community coalitions?

	Yes		No		Don't Know	
	Executives	Presidents	Executives	Presidents	Executives	Presidents
a. health-care cost	6	11	6	33	1	2
b. business/labor	7	14	7	31		2
c. hospital	10	30	3	16		1
d. Chamber of Commerce	7	9	5	35		2
e. AIDS	9	18	3	28		2

3. To your knowledge, in the past two years has your society sponsored or participated in:

	Yes		No		Don't Know	
	Executives	Presidents	Executives	Presidents	Executives	Presidents
a. health fair displays	9	14	4	26		3
b. public forums	6	16	7	32		
c. newspaper supplements	5	17	8	31		
d. newspaper columns	8	13	5	31		2
e. television shows	4	11	9	34		
f. radio spots or shows	5	12	8	34		1

4. When a reporter asks your society for assistance with a story, does the society:

11	29	generally respond
2	6	respond on occasion
		rarely respond

County Collection . . .

County medical society survey . . . *continued*

5. If and when your society responds to a media request, who usually does the interview?

10	28	the president or other officer
2	15	whoever is willing to do it
3	5	the society executive (where applicable)
1	3	other (please specify) specialist
	2	don't respond

6. How would you describe the media coverage of your society and doctors in general in the local media?

8	27	usually fair
4	9	usually unfair
1	13	no coverage

7. The OSMA occasionally sends "Media Alert" information packets to county society presidents and executives when major news stories break (for example HCFA release of mortality data, Medicare cutbacks, etc.). Do you find these useful?

12	45	Yes
1	3	No
1	1	Aren't familiar with them

8. Would you be willing to attend a free ½-day seminar, held in your region of the state, to learn more about the techniques you can use to do more effective news media interviews?

8	28	Yes
5	9	No

9. Do you have any further comments you would like to make regarding how the OSMA can improve its services to the county medical societies?

Executives:
"[I] am surveying my membership for their input. Personally, I feel OSMA does a very good job in communicating with me and responding to all my inquiries."

Presidents:
"I am very pleased with the activities of the OSMA and have found them very cooperative on all occasions and actively involved. I believe that they do a fine job. I feel that the auxiliary and contacts are quite good. The one area where I feel that we might have additional input, is if we could somehow manage to involve the people in the office and perhaps even involving some relationship with local nursing units; if not in the hospitals, then certainly those who function in physicians' offices. I feel (that) to continue the present activities and high level of cooperation should be our goal. I have no really specific recommendations and I certainly have no complaints about the state society. I have no idea what the outlook and relationships with other state organizations are across the country, but I am certainly pleased with our relationship with OSMA and hope we can continue in this high spirit of cooperation and support."
"Annual meeting at OSMA with county execs and presidents."
"OSMA and its people have always been greatly responsive to our local county needs."

OBITUARIES

H. FRED BANFIELD, JR., MD, East Liverpool; University of Louisville School of Medicine, Louisville, KY, 1943; age 73; died February 17, 1989; member OSMA and AMA.

JAMES R. BELL, MD, Cleveland; Harvard Medical School, Boston, MA, 1925; age 87; died March 11, 1989; member OSMA and AMA.

RALPH B. BURNER, SR., MD, Myrtle Beach, SC; Medical College of Virginia Commonwealth University School of Medicine, Richmond, VA, 1951; age 67; died February 20, 1989; member OSMA and AMA.

ALEXANDER CALDER, MD, Youngstown; New York Medical College, New York, NY, 1952; age 62; died February 22, 1989; member OSMA.

PAUL CORSO, MD, Salem; St. Louis University School of Medicine, St. Louis, MO, 1932; age 83; died February 7, 1989; member OSMA.

WILLIAM H. CRADDOCK, MD, Cincinnati; University of Minnesota Medical School, Minneapolis, MN, 1929; age 84; died March 14, 1989; member OSMA and AMA.

GRECIO T. DERIKITO, MD, Wellington; Faculty of Medicine and Surgery University of Santo Thomas, Manila, Phillippines, 1956; age 62; died February 26, 1989; member OSMA and AMA.

DANIEL V. DOUGHERTY, MD, Ft. Lauderdale, FL; Johns Hopkins University School of Medicine, Baltimore, MD, 1933; age 83; died March 2, 1989; member OSMA and AMA.

EDWARD A. GATZ, MD, Shreve; Louisiana State University School of Medicine, New Orleans, LA, 1949; age 67; died March 3, 1989; member OSMA and AMA.

MATTHEW GINSBURG, MD, Toledo; University of Pennsylvania School of Medicine, Philadelphia, PA, 1929; age 84; died February 10, 1989; member OSMA and AMA.

FRANK M. GOOD, MD, Toledo; University of Pittsburgh School of Medicine, Pittsburgh, PA, 1950; age 69; died December 18, 1988; member OSMA and AMA.

CARL W. HAHN, MD, Fairview Park; Case Western Reserve University School of Medicine, 1930; age 84; died February 20, 1989; member OSMA and AMA.

JOSEPH M. HERBERT, MD, Washington C.H.; Ohio State University College of Medicine, 1942; age 72; died February 2, 1989; member OSMA and AMA.

DONALD D. KHYM, MD, Sandusky; Severance Medical College Yonsei University, Seoul, Korea, 1950; age 66; died January 21, 1989; member OSMA and AMA.

KURT E. LANDE, MD, Hamilton; Friedrich-Wilhelms Universitaet Medizinische Fakultaet Berlin, Berlin, Germany, 1925; age 87; died February 13, 1989; member OSMA and AMA.

TOWNSEND G. LOWE, MD, Los Angeles, CA; Meharry Medical College, Nashville, TN, 1939; age 79; died November 19, 1988; member OSMA.

HERMAN W. MANNHARDT, MD, Avon, CT; Wayne State University School of Medicine, Detroit, MI, 1937; age 77; died January 3, 1989; member OSMA and AMA.

JAMES W. MCGOUGH, MD, Columbus; University of Louisville School of Medicine, Louisville, KY, 1934; age 78; died October 19, 1988; member OSMA and AMA.

JORGE MEDINA, MD, Mentor; Facultad de Medicina de la Universidad Nacional Automona de Mexico, Mexico, 1947; age 68; died February 9, 1989; member OSMA and AMA.

RAMESH MEHTA, MD, Massillon, B.J. Medical College Gujarat University Ahmedabad, Gujarat, India, 1956; age 56; died February 10, 1989; member OSMA and AMA.

PAUL G. MODIE, SR., MD, Parkersburg, WV; Rush Medical College, Chicago, IL, 1932; age 86; died February 17, 1989; member OSMA and AMA.

MELVIN A. MULVANIA, MD, Lima; Rush Medical College, Chicago, IL, 1929; age 85, died March 26, 1989; member OSMA and AMA.

ELWOOD GEORGE NADER, MD, Cleveland; University of Louisville School of Medicine, Louisville, KY, 1950; age 64; died February 10, 1989; member OSMA and AMA.

ROBERT A. PORTERFIELD, MD, St. Clairsville; Jefferson Medical College of Thomas Jefferson University, Philadelphia, PA, 1944; age 70; died January 15, 1989; member OSMA and AMA.

H. JUDSON REAMY, MD, New Philadelphia; Indiana University School of Medicine, Indianapolis, IN, 1951; age 62; died January 3, 1989; member OSMA and AMA.

ALDO F. REY, MD, Miami, FL; Universidad Nordestana San Francisco de Marcoris, Dominican Republic, 1983; age 37; died August 16, 1988; member OSMA and AMA.

WILLIAM W. ROBY, MD, Palm Coast, FL; Ohio State University College of Medicine, 1951; age 66; died January 31, 1989; member OSMA and AMA.

LESTER A. RUSSIN, MD, Miami Beach, FL; University of Cincinnati College of Medicine, 1937; age 80; died January 20, 1989; member OSMA.

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DIFFERENCES IN CANCER MORTALITY RATES IN OHIO COMMUNITIES WITH RESPECT TO URANIFEROUS GEOLOGY

Anthony J. Dzik, PhD

Populations in areas of uraniferous geology may be at risk from radon emissions. Twenty-eight municipalities were examined as to their location with respect to uraniferous geology. Communities with possible radon risk had higher rates for all cancers and cancer of the respiratory system, but differences were not statistically significant. Some possible reasons for the results are discussed.

Introduction

Radon, a colorless, odorless gas generated from the natural decay of uranium-238, could be responsible for 5,000 to 20,000 cases of lung cancer in the United States each year.[1] Until recently, radon was thought to pose health risks only to miners and persons in mining areas, but now it appears that some of the general population may also be at risk.[2,3,4] It may be that some of those people at greatest risk reside in areas of uraniferous geology. For example, Wilkinson[5] found high mortality rates for gastric cancer in New Mexico counties with significant uranium deposits. A study of county cancer mortality rates in the U.S. showed that all cancer and lung cancer rates are higher in areas of uraniferous geology, but the results did not prove statistically significant.[6]

Although radon release is almost ubiquitous, the greatest releases appear to be found in areas with uranium-containing granitic rocks and uraniferous black shales. In the state of Ohio, black shales containing amounts of uranium significantly above the average content of the earth's crust (2-3 ppm) are fairly widespread.[7] The Ohio black shale is generally well-endowed with uranium concentrations, often ranging from 10 to 40 ppm.[8] Although this rock type underlies much of the eastern half of Ohio and the far northwest corner, it appears to be a potential health threat only when it is found near the surface. Harrell and Kumar[7] believe that most of Ohio's radon problems will be associated with the Ohio shale and certain glacial sediments.

The intent of this study is to examine whether any significant differences in cancer mortality rates exist between Ohio communities with uraniferous geology and those without such geology. The hypothesis to be tested is that radon-risk communities have higher cancer mortality rates than those of probable non-risk communities.

Summary

Radon emissions in areas of uraniferous geology may lead to higher cancer rates in Ohio communities situated on such geology. Areas with outcrops of Ohio shale and areas with uranium surface concentrations exceeding 3 ppm were considered possible risk areas.

A sample of 28 Ohio communities was divided into possible radon-risk and non-risk groups and differences in age-adjusted mortality rates.

For all cancer, digestive and respiratory cases were assessed. While observable differences occur between the two groups, two sample t-tests suggest the differences are not statistically significant. The statistics were notably higher when considering a division between communities in areas of uranium surface concen-

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Figure 1

Regions of Ohio shale outcrops

Figure 2

AERIAL RADIOMETRIC URANIUM SURFACE CONCENTRATION

Above 3 ppm

Below 3 ppm

trations above 3 ppm and those below. This could be taken to suggest that surface concentrations, are a better indicator than Ohio shale of potential radon risk. Problems of sample size and multi-factorial etiology are also discussed.

Methodology

To ascertain whether any differences exist in cancer mortality rates in radon-risk and non-risk communities, a random sample of 28 Ohio municipalities was selected for observation.

Crude mortality rates (number of deaths per 100,000 population per year) for all cancer sites (ICD #140-208), cancer of the digestive system (ICD #150-159), and cancer of the respiratory system (ICD 160-165) were computed for each sample municipality for the three-year period 1983-1985. A three-year period was selected to minimize the chance of choosing a year in which the number of deaths might be uncharacteristic. Data on the number of deaths by community were taken from *Vital Statistics of the United States Vol. II, Mortality Part B*[9] for each year. Because crude rates can be misleading because of age structure differences, the crude rates were age-adjusted to the 1980 U.S. population (age-adjustment indicates what the death rates would be in each enumeration unit if they possessed the same age distribution). The age-adjusted rates served as the variables for testing.

The sample was then divided into communities located on Ohio shale outcrops (potential radon-risk) and communities not situated upon such geology (non-risk). This division is illustrated in Figure 1. Because this division may have been too general with regard to risk (interpretation problems resulting particularly from the various thicknesses of overburden and the fact that some places without shale outcrops have glacial sediments which may be uraniferous), a second division was also employed. The sample was divided into communities where uranium surface concentrations exceed 3 ppm and those with levels below 3 ppm. These data were taken from a map appearing in Harrell and Kuman,[7] and the division is illustrated in Figure 2.

The working hypothesis is that the cancer mortality rates are higher in the potential radon-risk communities than in the potential non-risk areas. Two-sample t-tests were applied to determine whether differences existed in the age-adjusted mortality rates of the two groups.

Results and Discussion

Table 1 provides the mean age-adjusted cancer mortality rates and the results of the t-tests for the sample when divided into places on Ohio shale and those not on Ohio shale. There are observable differences for all cancers and respiratory system cancer (slightly higher rates on Ohio shale). For gastric cancer the mean rate of the non-shale communities is slightly higher than that of the shale places. None of the t-statistics, however, are statistically significant, indicating that differences could be chance events.

Table 2 provides the mean age-adjusted cancer mortality rates

Table 1
Mortality rate differences between Ohio communities on Ohio shale and those not on Ohio shale

All cancer (ICD #140-208)	N	Mean*	S.D.
On Ohio shale	12	247.1	98.4
On other geology	16	233.3	82.9
t = .392, not significant			
Cancer of digestive system (ICD #150-159)	**N**	**Mean***	**S.D.**
On Ohio shale	12	54.3	19.6
On other geology	16	56.0	29.7
t = .182, not significant			
Cancer of respiratory system (ICD #160-165)	**N**	**Mean***	**S.D.**
On Ohio shale	12	68.4	43.9
On other geology	16	65.7	25.8
t = .191, not significant			

*mean age-adjusted mortality rate

Table 2
Mortality rate differences between Ohio communities with radiometric uranium surface concentration above 3 ppm and those less than 3 ppm

All cancer (ICD #140-208)	N	Mean*	S.D.
>3 ppm	9	292.9	102.7
<3 ppm	19	213.7	70.5
t = 2.091, not significant			
Cancer of digestive system (ICD #150-159)	**N**	**Mean***	**S.D.**
>3 ppm	9	65.4	33.1
<3 ppm	19	50.6	20.0
t = 1.237, not significant			
Cancer of respiratory system (ICD #160-165)	**N**	**Mean***	**S.D.**
>3 ppm	9	79.7	47.4
<3 ppm	19	60.8	26.9
t = 1.119, not significant			

*mean age-adjusted mortality rate

and t-statistics for the sample as divided into communities with radiometric uranium surface concentrations above 3 ppm and those below 3 ppm. The mean rates for all three cancer mortality categories are higher in the above-3 ppm communities. The t-statistics are stronger than the ones reported for the other division but still lack statistical significance.

The data and results suggests that while observable differences may exist between cancer rates in areas with possible radon geology and those areas without that attribute, the analyses were not significant. A possible interpretation problem stems from sample size. Statistical significance can be enhanced by utilizing a larger sample. It is interesting, however, to note that the differences were greater in the second division of the sample; this could be taken to suggest that actual radiometric uranium surface concentrations might be a stronger indicator of radon potential than Ohio shale geology. For example, some of the communities on Ohio shale are located in areas of low uranium surface concentrations.

As with any investigation into cancer epidemiology, it must be kept in mind that most cancers have a multi-factorial etiology. Therefore, radon can only be part of the story. For example, if the mean death rate of the low-uranium concentration communities is taken as a norm, then the nine high concentration communities have 148 excess deaths from all cancers each year, 27 excess deaths from digestive system cancer, and 35 excess deaths from cancer of the respiratory system. How many of these deaths are radon-related? Many of the nine communities, e.g., Ironton, Lima, Chillicothe, are highly industrialized and have other potential carcinogens in their locales. Also, aggregate data such as examined here ignore personal risk factors such as smoking habits, occupation, diet, etc.

Despite the limitations, this study is suggestive. Enlarged samples and replication may enhance statistical significance and lend credence to the hypothesis that areas with uraniferous geology have higher cancer rates than areas without that possible risk.

Conclusion

Examination of a sample of 28 Ohio communities suggests the possibility of greater cancer mortality rates in areas of Ohio shale and in areas where surface concentrations of uranium exceed 3 ppm. The mortality differences between uraniferous and non-uraniferous places, however, were not statistically significant. Although observable differences occurred in general cancer and respiratory cancer, it is noted that the excess deaths in uraniferous communities cannot be solely attributed to radon.

REFERENCES

1. Schneider C: The indoor pollution burden. *EPA Journal,* August 14, 1986.
2. Hess CT, Weiffenbach, CV, Norton SA: Environmental radon and cancer correlations in Maine. *Health Physics* 45: 339-348, 1983.
3. Lillie DW: *Our Radiant World,* Ames, Iowa, Iowa State University Press, 1986.
4. United States Environmental Protection Agency: The radon problem: an overview. *EPA Journal,* August 2, 1986.
5. Wilkinson G: Gastric cancer in New Mexico counties with significant deposits of uranium. *Arch Env. Health* 6:307-312, 1985.
6. Dzik, AJ: Cancer mortality rates in potential radon-risk and non-risk counties. *Geographical Perspectives.* In press.
7. Harrell JA, Kumar A: Radon hazards associated with outcrops of the Devonian Ohio shale. Final report for a grant awarded by the Ohio Air Quality Development Authority, University of Toledo, 1988.
8. Swanson VE: Oil yield and uranium content of black shales. U.S. Geological Survey Professional Paper 356-A, 1960.
9. U.S. Dept. of HEW: Vital Statistics of the United States Vol. II Mortality Part B, 1983, 1984, 1985. Washington.

The Physician in Court . . . Preparing for a Malpractice Trial

The increased frequency of lawsuits brings added pressure upon physicians who appear in court — either as a defendant in a medical professional liability case or as an expert witness.

If it is a first courtroom experience, it likely will be a time of even greater anxiety. Some basic factors, however, can help in the preparation for a jury trial.

As you review the case with your attorney, the following suggestions should become part of the discussion to better acquaint you with the techniques of testifying before a jury.

The objective is to take all steps necessary to ensure that the jury perceives you in the best possible manner. Appropriate demeanor, attitude and appearance are essential concerns.

Preparation. You will be far more comfortable if you have been familiarized with all aspects of your case. Do not hesitate to discuss any questions you may have with your defense counsel.

Courtroom procedure. If this is your first experience, it may help to listen to a trial or attend several court sessions to observe the way procedure is handled.

Attitude. Courteous presentation of testimony by the physician can be a great help. Attention to even the smallest details may have significance; for example, one of the most important words used in a courtroom is "sir." In using it, the witness reflects an air of humility that will be noticed by the jury.

Addressing the jury. Focusing on the jury — rather than upon others in the courtroom — makes jurors feel that they are the important part of the proceedings.

Appropriate appearance. Clothing that is plain, neat and conservative is best for a court appearance. There have been instances in which a physician's appearance — either in clothing that is too flashy or too casual — has been distracting or even offensive to the jury.

While it can be advantageous to have a spouse and/or older children accompany you to the trial, it is important that these family members wear clothing that is neat and conservative. Too much jewelry must be avoided.

In presenting testimony, the physician must be:

Confident. As a witness, the objective is to sell yourself. A professional demeanor reflects self-assurance.

Decisive. Answers should be kept as short and as simple as the subject matter allows.

Firm and believable. As long as you are courteous and consistent, you need not feel you have to explain away your opinion or dilute it in any form.

Distinct. Speaking clearly, in a voice loud enough for jurors to hear, is important. Using layman's language rather than complex medical jargon also will help the jury. Answer only the question you are asked and nothing more.

Cooperative. Never argue with the plaintiff's attorney or the judge. Part of the cross-examination process involves questions that will make the witness lose control.

Preparing in advance with your defense counsel can help eliminate some fear of the unknown. As part of the review process, you should be aware that certain questions invariably will be asked of you in court. Some of these are: "How many times have you testified?" "Have you talked to anybody about this lawsuit?" And if you are testifying as an expert witness, you undoubtedly will be asked: "Doctor, you have been paid to testify at this trial, haven't

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Another Look at Cancer

By Miriam Malley; Vantage Press, New York; 96 pages; $8.95

The author fosters the hypothesis that malignant diseases in humans appear as a result of three conditions: (1) a chronic calcium deficiency, (2) a chronic stress of mind and body, and (3) a lesion of chronic nature that continuously promotes the healing mechanisms. Such a simplistic view of the complicated phenomenon of human neoplasia is built upon a superficial review and very personal interpretation of selected cancer-related literature.

The book describes the literature research done by "Jan" (a graduate student at Yale University) while attending a seminar course in the School of Public Health. She soon became aware of the fact that "after a half-century of inquiry, no one had yet found the cause of cancer. She wondered why." So she immersed herself into the great vastness of cancer literature and found anomalies in cancer research. In her opinion medical doctors are not scientists, they are dispensers of pills and use the wrong kind of reasoning when approaching the causes of diseases. So she decides to apply "scientific reasoning" to the subject of cancer, and after reviewing the literature develops the already mentioned hypothesis on the development of cancer.

The arguments used by the author to substantiate this naive theory border on the absurd. Out of context quotations ("fresh milk may play a part in preventing cancer of the liver") are abundant in the book and are used to build a very weak structure of reasoning. Dietary studies that do not support her theory are quickly discarded as worthless while her own simplistic questionnaire (presented in the book's appendix) acquires immeasurable value when it shows that low calcium intake is prevalent among cancer patients. Hans Selye's studies on the "alarm syndrome" are utilized to paint a picture of life as a continuous stress that eventually conduces to the development of chronic lesions and to explain the higher incidence of cancer on the poor. You can fight stress with a hobby. Golfing, walking and swimming are good hobbies, but jogging is a "no-no."

"The arguments used by the author to substantiate this naive theory border on the absurd."

To emphasize the concept of chronic lesions as causative of cancer, Mallay describes the development of lung cancer in chronic smokers. And she puts forth a new theory that clashes with all present scientific knowledge: The particulate matter in the smoke ravages the alveoli and the chronic reparative process in this delicate tissue triggers the neoplastic process. This chronic damage to tissues also explains the appearance of metastases in distant organs.

Obviously this is not a book intended for the medical profession. If the author's intention is to help cancer patients understand the disease, its causes and prevention, she has failed to present scientific evidence to support her theory. The editors state that the book "will have a revolutionary impact on the way we view cancer" and offer hope that cancer can be prevented by changes in the American diet and lifestyle. Mallay's essay cannot be recommended as another resource for cancer patients. It contains too many inaccuracies, and the theories put forward are based on tenuous grounds. — **Alfonso E. Barnes, MD.** *Dr. Barnes specializes in gynecological oncology in Cincinnati.*

What is "Women in Medicine" All About?

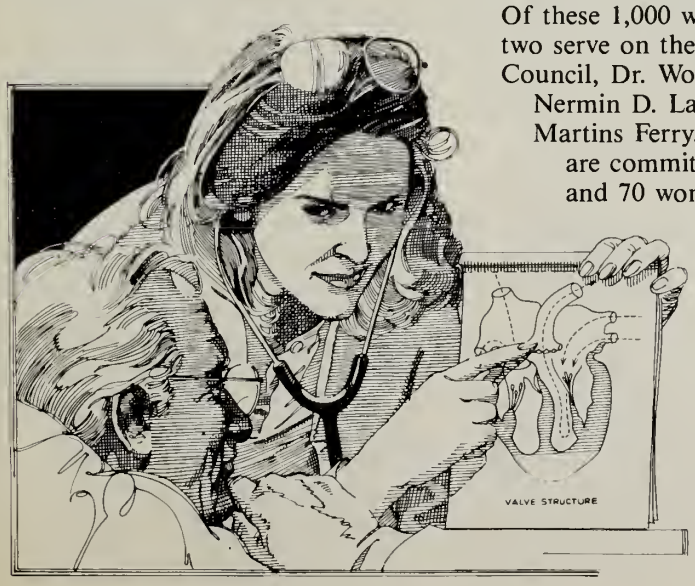
In 1979 the Women Physicians Committee was formed by the American Medical Association. The AMA "Women in Medicine" program began in 1984 and, in recognition of the large and continually increasing number of women physicians, reached departmental status at the AMA in 1989.

Claire V. Wolfe, MD, of Columbus has been active in the AMA program and currently is vice chairman of the Women in Medicine Advisory Panel to the AMA Board of Trustees. Dr. Wolfe stated that "their goal is to mainstream women into organized medicine in the same proportion as men are in organized medicine. The prime goal is to get women active."

She continued, "To that end, we are trying to network with other groups such as academicians, psychiatrists, etc., telling people what's going on. We have developed a data bank of women who would be willing to speak, creating more visibility for women physicians, and are currently working on child care issues."

There are about 3,600 women physicians in Ohio, and close to 1,000 of these belong to OSMA.

Of these 1,000 women members, two serve on the OSMA Council, Dr. Wolfe and Dr. Nermin D. Lavapies, of Martins Ferry. Two women are committee chairmen and 70 women serve on various OSMA committees.



One of the county societies that has an active "Women in Medicine" committee is the Academy of Medicine of Cincinnati, which formed it in 1986.

At that time there were no women in committee chairman positions. Now there are four women on council, three women committee chairmen and two women vice chairmen as well as other women serving on the various committees.

In January 1986 Cincinnati physicians united to form their Women in Medicine Committee of the Academy of Medicine of Cincinnati. They have two primary purposes: 1) to encourage and aid women's involvement in organized medicine and 2) to build a support system for addressing the unique concerns of women in medicine.

The committee has placed special emphasis on these aims:

- Nurturing interpersonal and professional relations among women colleagues;
- Fostering women's leadership in organized medicine;
- Promoting public education, particularly awareness of protective health care;
- Providing community service;
- Establishing networking and mentoring systems among colleagues, medical residents and students;
- Offering information to Academy members on available child care options;

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revealed that most people changed physicians not for reasons of competence but because of the doctor's style or office manner. They were troubled by insensitivity to their needs, or poor communication techniques, or by lack of respect for the patient's views, or by over-emphasis on technology. Here were some representative responses:

"I left the doctor's office feeling worse than when I came, and that is not what I went there for."

"I waited almost two hours for my turn and no sooner did I get into the doctor's office than he became involved in a long personal telephone call."

"I don't think the doctor really understood what I was saying. He put me into a long series of tests even before I finished telling him my symptoms."

"The doctor smoked and I thought that anyone who had so little regard for his own health should not be entrusted with mine."

"My doctor had gained a lot of weight since our last meeting and was quite obese and I had difficulty in taking him seriously."

"When he told me what was wrong, it was so cold and matter-of-fact that I felt he didn't care whether I would get well or not."

"The doctor sent me bad news by registered mail. I suppose he wanted to protect himself but he lost a patient. I am not a legal item or oddity but a human being."

"The prescription the doctor gave me had terrible side effects he didn't warn me about."

"I don't think he respected my intelligence or my right to ask what I thought were relevant questions."

The questionnaire had an even greater impact on medical students than I dared hope. The information it turned up had pocketbook significances, hardly a "soft" fact in itself. It had something to do with the shine on the shingle. Whenever I presented the results of the questionnaire, whether in class or in informal supper get-togethers, I discovered that the medical students were not inattentive.

An article about the questionnaire survey appeared in the *New England Journal of Medicine* and resulted in substantial correspondence. The consensus of the letters was that while patients should not be allowed to dictate the nature of medical practice, they were the final arbiters of the quality of medical practice. And, so long as patients had freedom of choice in the selection of physicians — a principle stoutly defended by the medical profession — the way they exercised their choice could be a life-or-death matter for medical practitioners.

One of my colleagues at UCLA was not at all pleased by the results of the survey — especially by the importance attached by people to compassion and communication skills. He said he was not interested in charming his patients or winning popularity contests. He said he wanted to give them the benefit of his special skills and knowledge. He said that if he himself were ill, he would select a physician who could make a correct diagnosis and who would know exactly what had to be done — rather than choose one who was adept at sweet talk or at making friends and influencing people, or in gaining a reputation as one hell of a nice fellow.

I believe my colleague may have missed the main point. He assumed that a doctor had to be one or the other; that if he is competent he couldn't be compassionate. He seemed to believe that the science of medicine and the art of medicine functioned on different levels and in different ways.

Another colleague felt that too much emphasis was being given to communication techniques.

"What do you want me to do?" he asked. "Do you want me to hedge or dissemble in communicating a diagnosis? I have the obligation to tell what I know. My patients are entitled to the truth and I have the obligation to give it to them. My lawyer tells me that if a patient discovers that his condition was worse than I led him to believe, I could be in line for a malpractice suit that could wipe me out."

And again, I felt that my colleague may have missed the point. Certainly, he had the obligation to tell the truth but he also had the obligation to tell it in a way that did not leave the patient in a state of emotional devastation — the kind of emotional devastation that could compromise effective treatment. Medical students spend years in learning how to diagnose but only minutes in learning how best to convey it.

Question: Is it possible to inform a patient truthfully about a serious diagnosis and still leave the patient with something to hold onto in the form of sustaining hope?

Of course it is. I have been with cancer patients at the time of diagnosis. I recall one circumstance in particular. I listened to a physician as he told the truth. He put it in the form of a challenge rather than a death sentence. He was not telling less than he knew; neither was he telling more than he knew. In his medical journals he had read of hundred of unexpected remissions. In his own practice he knew that patients who didn't deny the diagnosis but defied the verdict seemed to do better than others. And so he didn't feel under any obligation to provide any terminal date — nor would he have done so even if asked. He was wise enough to know that some people confound all the predictions — and he didn't want

to do anything or say anything that would have the effect of a hex on the patient.

Unquestionably, some doctors tend to discourage discussions in which patients present their own notions about their illness. Most of the physicians I know, however, believe that the key to sound medical practice is to be found in listening carefully to the patient, however wide of the mark the theories may seem. Somewhere in the swirl of words there may be valuable clues that the physician can put to good use. Moreover, talking provides catharsis for the patient. Just in the act of expressing himself or herself, the patient's anxiety may be lessened. Since anxiety and depression are unfortunate concomitants of disease, most physicians genuinely welcome the desire and ability of patients to unburden themselves of their fears and portents.

People go to see doctors out of fear and hope — fear that something may be wrong but hope that it can be set right. If these emotional needs don't figure in the physician's approach, he may be treating half the patient. The question is not now — anymore than it has ever been — whether physicians should attach less importance to their scientific training than to their relationships with patients, but rather whether enough importance is being attached to everything involved in effective patient care.

The most important recent change in the practice of medicine, I believe, may be represented by the enlarged knowledge and new respect for the apothecary built into the human system. This new emphasis has been accompanied, logically enough, by increased attention to the concept of the patient-physician partnership, in which the physician brings the best that modern medical science has to offer and the patient brings an environment congenial to treatment, by which is meant confidence in the physician, a strong will to live, and a determination to get the best out of whatever is possible.

Few things are more exciting about the human body than the wide array of forces within it that are poised to do battle with invaders or abnormalities. The body possesses an immune system designed to meet the challenge of illness. Different cells in the immune system do different things. "Sentry" cells roam throughout the body, locating and identifying intruders or abnormal situations, and then summoning the body's own defenders — cells that can pry open malignant cells and inject the body's own poisons; cells that can destroy infecting agents; cells that can even arrest viruses and summon reinforcements.

It is only in recent years that extensive knowledge has been accumulating on the immune system, its component parts, and its interactions with the rest of the human body. Included in the functioning of the immune system are the brain, the spleen, the thymus gland, bone marrow and lymph nodes. It is a mistake, therefore, to think of this immense system as located in any one place or as confined to any single process. It is connected to the body's vast network of organs and systems.

Similarly, if one asks — "What are the primary influences on the immune system?" — the answer is, practically everything. The immune system can be affected by biochemical changes in the body, by an invasion of microorganisms, by toxicity, by hormonal forces, by emotions, by behavior, by diet, or by a combination of all these factors in varying degrees. The immune system is a mirror to life, responding to its joy and anguish, its exuberance and boredoms, its laughter and tears, its excitement and depression, its problems and prospects. Scarcely anything that enters the mind doesn't find its way into the workings of the body. Indeed, the connection between what we think and how we feel is perhaps the most dramatic documentation of the fact that mind and body are not separate entities but part of a fully integrated system. **OSMA**

Norman Cousins is with the School of Medicine, University of California at Los Angeles (UCLA), Los Angeles, California.

Part II of Norman Cousins' article will appear next month.

Loss Awareness . . . *continued*

you?" Your attorney will help you anticipate such questions and help you deal with them accordingly.

A court appearance and the entire legal process surrounding a malpractice lawsuit always will be accompanied by anxiety. Even when you are not on the witness stand, it is important to listen attentively to the testimony of other witnesses.

Similarly, it is vital to show interest in what is occurring in the courtroom. Avoid appearing bored or impatient with the proceedings, because the impression made upon the jury in this regard can be crucial.

You know more about this case than anyone else . . . and you can be of immeasurable assistance to your defense, and to your defense counsel, during the trial proceedings. **OSMA**

The Loss Awareness Bulletin is provided each month through the OSMA Task Force on Professional Liability and its Subcommittee on Loss Awareness.

- Presenting seminars and programs of specific interest to women physicians and;
- Extending our network to other women's professional organizations such as the Cincinnati Womens Political Caucus, Greater Cincinnati Lawyers Association, Womens Health Consortium and others.

When asked to comment on "Women of Medicine," Susan Weinberg, MD, treasurer and member of the Academy Board and chairman of the Membership Recruitment Committee, said she "thinks the committee's primary intent is to teach and help women how to become involved in the mainstream of organized medicine. Any other goals are secondary to that. Women in medicine committees should be temporary because once this purpose is accomplished, there is no need for its future existence. They are not social groups nor a formal one needing a set of bylaws. Many women physicians feel they are isolated and there is no chance for them to serve in leadership positions. The women in medicine committee can be the step to educate and involve women in medical leadership and address their need to feel comfortable in this capacity.

"There really has been no nurturing of women physicians who have put their careers on hold because of other commitments. Once established in medical practice, women physicians need to become acquainted with the system and learn what committee and leadership responsibilities are and how to become involved.

"The enrollment of women medical students at the University of Cincinnati has increased with 42% of the first-year medical students being women. Their opportunities for leadership roles will also increase.

"Women physicians in Ohio are encouraged to seek active roles in their county societies and the OSMA." — *The OSMA Department of Membership Development*

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VASOTEC is available in 2.5-mg, 5-mg, 10-mg, and 20-mg tablet strengths.

Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor

Warnings: *Angioedema.* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Heart failure patients given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed, caution should be observed when initiating therapy (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. If may be advisable to eliminate the diuretic (except in heart failure patients), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASDTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis. Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: *General: Impaired Renal Function.* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASDTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia. Elevated serum potassium (> 5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASDTEC. (See *Drug Interactions.*)

Surgery/Anesthesia. In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients

Angioedema. Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension. Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure, patients should be advised to consult with the physician.

Hyperkalemia. Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia. Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE. As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions:

Hypotension. Patients on Diuretic Therapy. Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release. The antihypertensive effect of VASDTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents. VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium. VASDTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium. A few cases of lithium toxicity have been reported in patients receiving concomitant VASDTEC and lithium and were reversible upon discontinuation of both drugs. Although a causal relationship has not been established, it is recommended that caution be exercised when lithium is used concomitantly with VASDTEC and serum lithium levels should be monitored frequently.

Pregnancy—Category C. There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not been clearly defined, VASDTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome. Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity.

Nursing Mothers. Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASDTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION: The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASDTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (79%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular. Cardiac arrest, myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*), cardiac arrest, pulmonary embolism and infarction; rhythm disturbances, atrial fibrillation, palpitation.

Digestive. Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis.

Nervous/Psychiatric. Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital. Renal failure, oliguria, renal dysfunction (see PRECAUTIDNS and DDSAGE AND ADMINISTRATION).

Respiratory. Bronchospasm, rhinorrhea, asthma, upper respiratory infection.

Skin. Herpes zoster, pruritus, alopecia, flushing, photosensitivity.

Other. Vasculitis, muscle cramps, hyperhidrosis, impotence, blurred vision, taste alteration, tinnitus.

A symptom complex has been reported which may include fever, myalgia, and arthralgia, an elevated erythrocyte sedimentation rate may be present. Rash or other dermatologic manifestations may occur. These symptoms have disappeared after discontinuation of therapy.

Angioedema. Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASDTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension. In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings

Serum Electrolytes. Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen. In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASDTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit. Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g% and 1.0 vol%, respectively) occur frequently in either hypertension or heart failure patients treated with VASDTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown). In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: *Hypertension.* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASDTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASDTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASDTEC alone, a diuretic may be added.

Concomitant administration of VASDTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment. The usual dose of enalapril is recommended for patients with a creatinine clearance >30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤30 mL/min (serum creatinine ≥3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure. VASDTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASDTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLDGY, *Pharmacodynamics and Clinical Effects.*) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Heart Failure Patients with Renal Impairment or Hyponatremia: In heart failure patients with hyponatremia (serum sodium <130 mEq/L) or with serum creatinine >1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DDSAGE AND ADMINISTRATION, *Heart Failure,* WARNINGS, and PRECAUTIONS, *Drug Interactions.*) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

For more detailed information, consult your MSD Representative or see Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486. J6VS18R2(817)

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Miscellaneous

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Obituaries . . . *continued*

MYRA SAHAJDAK, MD, Cleveland; Medizinische Fakultaet der Ludwig Maximiliams Universitaet, Muenchen, Bayern, Germany, 1950; age 67; died January 3, 1989; member OSMA and AMA.

SAUL J. TAMARKIN, MD, Palm Beach, FL; Ohio State University College of Medicine, 1927; age 86; died February 26, 1989; member OSMA and AMA.

OSCAR A. TURNER, MD, Youngstown; Case Western Reserve University School of Medicine, 1937; age 78; died February 23, 1989; member OSMA and AMA.

ROBERT DEAN WEEKLEY, MD, Parma; University of Maryland School of Medicine, Baltimore, MD, 1951; age 65; died January 8, 1989; member OSMA and AMA.

GEORGE M. WILCOXON, MD, Alliance; Pritzker School of Medicine of University of Chicago, Chicago, IL, 1935; age 84; died February 6, 1989; member OSMA and AMA.

NEVIA A. WILSON, MD, Columbus; Meharry Medical College, Nashville, TN, 1973; age 42; died January 15, 1989; member OSMA and AMA.

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Medicaid Reform . . . The AMA recently joined other medical organizations, religious and citizen groups and allied health professionals to publicize the need for Medicaid reform by sponsoring a full-page ad in the *Washington Post*. The ad read, in part, "Medicaid is supposed to meet the health-care needs of the poor. Yet Medicaid covers fewer than half of all poor Americans . . . Strengtening Medicaid won't solve the health crisis . . . but it will help the most vulnerable — America's poor."

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Congressional Directory . . . Physicians in the Key Contact Program and others who are regularly involved in the legislative process may want to own a copy of the "1989 Congressional Directory for the First Session of the 101st Congress." The guide provides a listing of all members of Congress, and the committee assignments and key officials in government. For a copy, contact the AMA.

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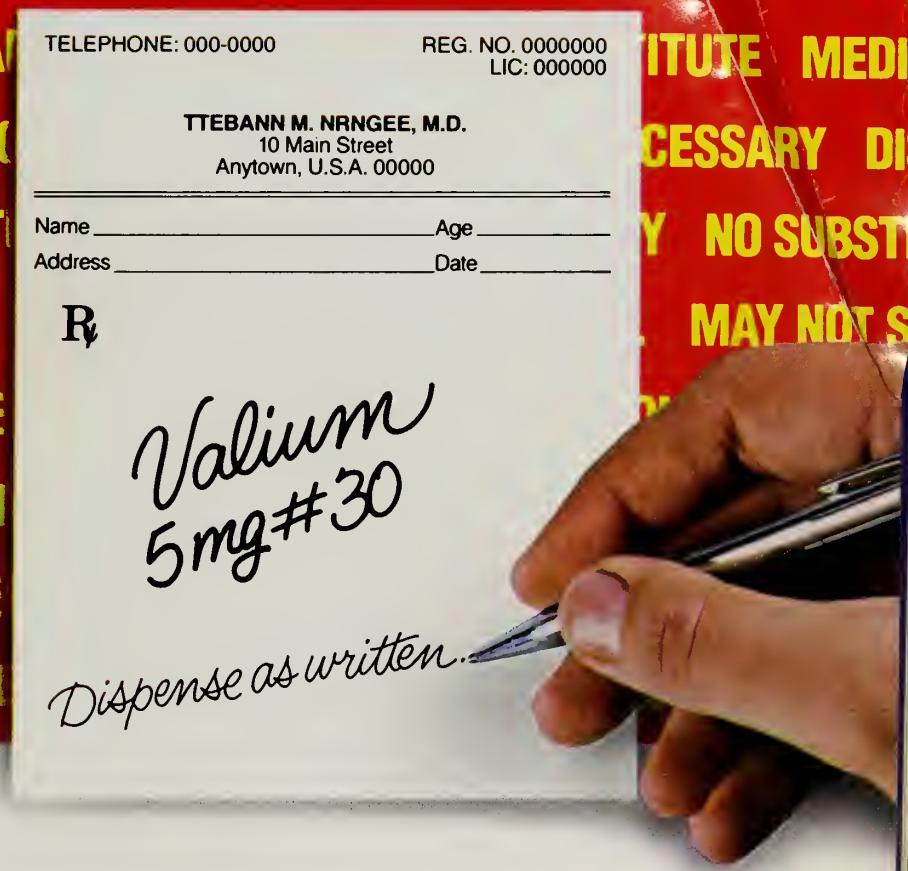

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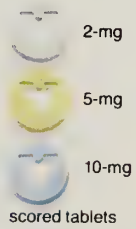

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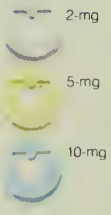

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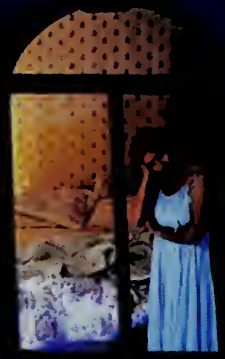

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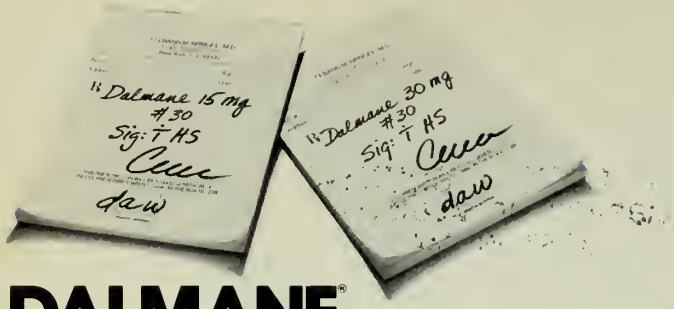

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References: 1. Koles JD, *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971 **2.** Koles A, *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Koles A, *et al. Clin Pharmacol Ther 19*:574-583, May 1976 **4.** Koles A, *et al Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR. *J Am Geriatr Soc 27*:541-546, Dec 1979 **6.** Dement WC, *et al. Behav Med 5*: 25-31, Oct 1978. **7.** Koles A, Koles JD. *J Clin Psychopharmacol 3*:140-150, Apr 1983 **8.** Tennant FS, *et al.* Symposium on the Treatment of Sleep Disorders, teleconference, Oct 16, 1984 **9.** Greenbloff DJ, Allen MD, Shader RI. *Clin Pharmacol Ther 21*:355-361, Mar 1977

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INDICATIONS: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

CONTRAINDICATIONS: Known hypersensitivity to flurazepam HCl; pregnancy Benzodiazepines may cause fetal damage when administered during pregnancy Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients at the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant Consider the possibility of pregnancy prior to instituting therapy

WARNINGS: Caution patients about possible combined effects with alcohol and other CNS depressants An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation Caution against hazardous occupations requiring complete mental alertness (e g , operating machinery, driving) Potential impairment of performance at such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

PRECAUTIONS: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia Consider potential additive effects with other hypnotics or CNS depressants Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function. Inform patients to consult physician before increasing dose or abruptly discontinuing flurazepam HCl

ADVERSE REACTIONS: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, e g., excitement, stimulation and hyperactivity

DRUG ABUSE AND DEPENDENCE: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines; more severe seen after excessive doses over extended periods, milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence

DOSAGE: Individualize for maximum beneficial effect. *Adults* 30 mg usual dosage; 15 mg may suffice in some patients *Elderly or debilitated patients* 15 mg recommended initially until response is determined.

SUPPLIED: Capsules containing 15 mg or 30 mg flurazepam HCl

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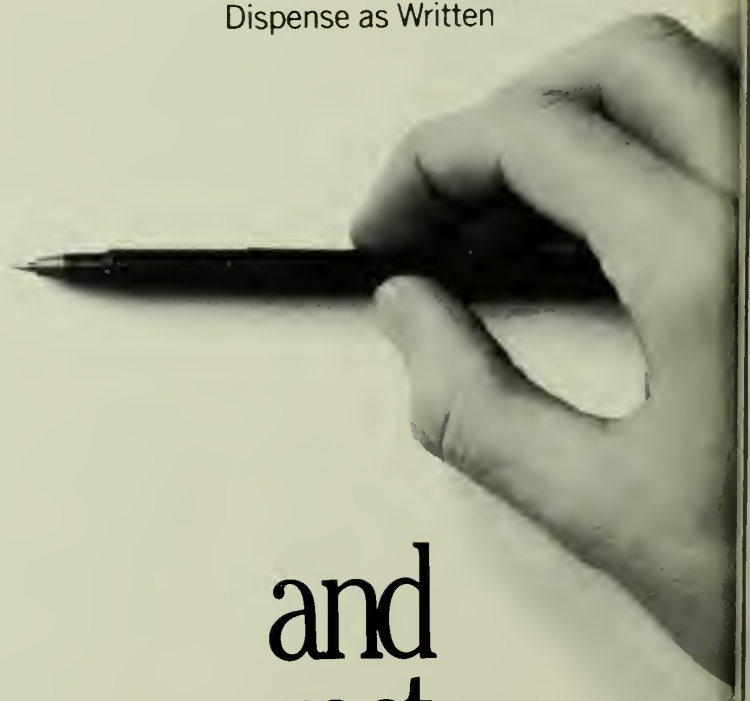

and rest your case.

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AUG 3 1989

Utrillo

James G. Ravin, MD, Chairman of the OSMA Art and Culture Committee

Maurice Utrillo (1883-1955) was a tragic figure who produced many wonderful paintings of the Montmartre district of Paris, but who suffered most of his life from alcoholism. He created moody views of the windy streets of Montmartre that are strangely void of people.

Utrillo received no formal training in art, but learned from his mother, who was also untutored. He succeeded in creating a style of painting that became very successful, although it suffered from overproduction. The Toledo canvas, dated 1910-11, was done in his "best" period, the years 1908-14. The twisty appearance of the buildings is enhanced by two different points of perspective, one above the other. Utrillo used an interesting mixture of paint and plaster of Paris to give the canvas an enhanced texture.[1] This fresh style of landscape painting brought him fame, including being named a chevalier of the Legion of Honor, and fortune.

He was the illegitimate son of Suzanne Valadon, who was also of illegitimate birth. Valadon had been a circus acrobat, a model for Degas and Renoir, and later a painter herself. Utrillo was introduced to alcohol in early childhood; his grandmother would put some in his soup to keep him quiet. Life at home was difficult for the young Utrillo, who was a moody, nervous, antisocial child who did poorly at school. While his mother led a bohemian life, his grandmother allowed him to roam about and become intoxicated frequently. By age 16 he was a confirmed alcoholic. His first of many hospitalizations for treatment of his alcoholism was two years later. Before he was 20, a physician told his mother Maurice was not demented, but exhibited infantile behavior and was not capable of any sustained work. He advised Suzanne to teach him painting since this would offer him something meaningful to do and might divert his attention away from alcohol. Utrillo did learn to paint well, but was not able to abstain from drink. He was docile when alone and sober, but rowdy and irritating when inebriated. Despite being an artist, he never entered a museum, and remained unmannered and undisciplined. If entrusted with money, it would go for wine, which earned him the nickname "Littrilo" for the enormous quantities he imbibed.[2,3] The family finally agreed that he would be under the care of a male nurse and his mother, and that he would never be allowed in public alone or he would be confined for life in an asylum. Several attempts have been made at post mortem analysis of Utrillo's personality. Certainly there was much psychopathology. He never knew his father. His mother left him to her mother to take care of while having several prolonged love affairs. One author has suggested that Utrillo had severe difficulty in resolving his Oedipus complex.[4] Fixated on his mother, he rebelled against father figures and people in authority including teachers and gendarmas. A need for self-punishment followed, which caused depression and suicide attempts. This was also an important factor in his destructive chronic alcoholism.

Although Utrillo never won his battle with alcohol, he did create a personal style of painting that has charm and is easily recognizable as his contribution to art. **OSMA**

1. Wittman O: Toledo Museum of Art, "European Paintings." Toledo Museum of Art, 1976, p. 161.
2. de Polnay P: "Enfant Terrible." "The Life and World of Maurice Utrillo." NY, Morrow, 1969, p. 81.
3. Werner A: "Utrillo." NY, Abrams, 1981, p. 16.
4. George W: "Utrillo." NY Graphic Society, Greenwich, CT 1960, pp. 23-27.

This month's cover is Utrillo's "Street in Montmartre." Mixed media on canvas, 1910-11. Toledo Museum of Art, gift of Edward Drummond Libbey.

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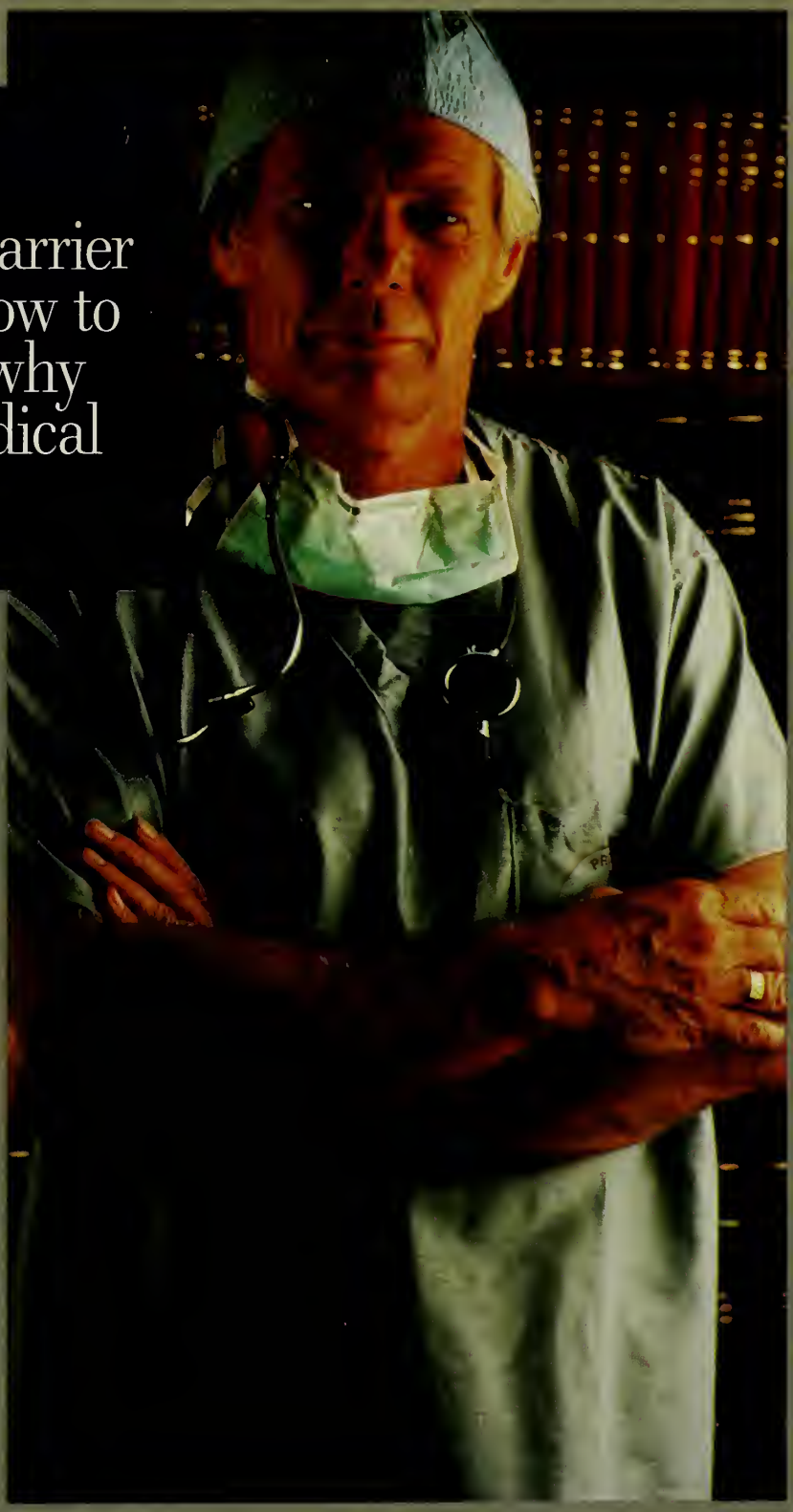

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USPS 405-200

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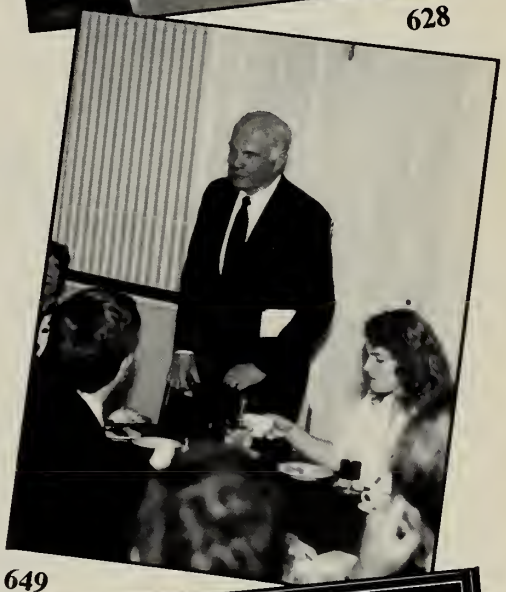

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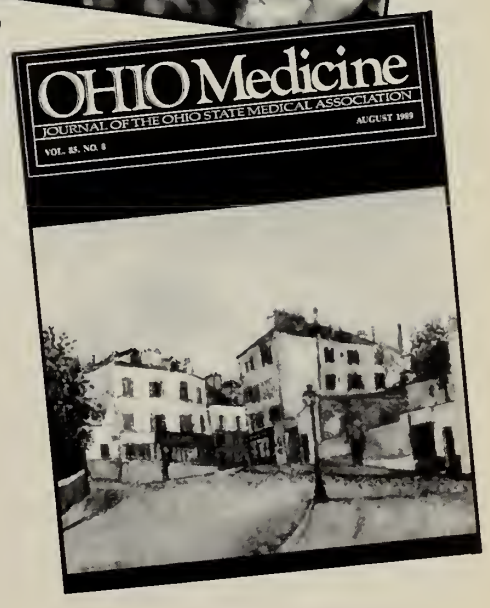

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Published monthly under the direction of The Council for and by members of OHIO Medicine, 1500 Lake Shore Drive, Columbus, Ohio 43204-3824, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1989 Subscription: $25 per year.

Send address changes to: OHIO Medicine, 1500 Lake Shore Drive, Columbus, Ohio 43204-3824.

Second Class Postage paid at Columbus, Ohio and at additional mailing offices.

OHIO Medicine does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

FROM THE EDITOR

Canadian Health Care? Draw Your Own Conclusions

As more and more problems are perceived with American's health-care system, everyone from politicians to the man and woman on the street seem to be turning envious eyes toward our neighbor to the north.

For many, Canada's national health-care system seems to be the panacea our country needs to mend its own health-care ills — a rapturous solution to high costs and rationing of care. But is it really? In this issue, three OSMA members take a look at the pros and cons of the Canadian health-care model . . . and draw some rather interesting conclusions. If you are frequently placed in a situation of defending our own country's health-care system . . . or have been wondering yourself whether our northern neighbor knows something we don't about providing quality health-care to its citizens . . . then you owe it to yourself to study the articles presented here. Even if you don't draw the same conclusions as our authors, you will at least have a better grasp of the facts — all the facts. And isn't that really the best way to draw a conclusion?

Speaking of drawing conclusions, that is exactly what the OSMA's Task Force on Health Insurance Issues asked you to do earlier this year when it sent around its survey on third-party payor inpatient review activities. Your conclusions are presented in the article "Third-Party Payor Calls — Nuisance or Necessity?" Give it a look . . . you may just identify your own conclusion from the hundreds the task force received.

By popular request, we are printing the remarks OSMA President William J. Marshall, MD, delivered to the House of Delegates shortly after his inauguration. It's a challenging and thought provoking speech, and if you weren't in attendance that Sunday night in May, you should give it your full attention. We think you'll find it inspiring . . .

Now that AIDS has become such a major concern for health-care professionals (not only how to treat the virus, but how to treat it safely), physicians are beginning to worry less about the risk posed by *other* infectious diseases they see — and that's a shame. Hepatitis is still a killer, every bit as deadly as AIDS, and physicians are dying from it, in increasing numbers. Staff writer Michelle Carlson takes

continued on page 594

Learning From Medical Students, Part II

By Norman Cousins

Editor's Note: This concludes Norman Cousins' two-part series on medical students. Part I appeared in the July '89 issue of **OHIO Medicine.**

It is only in the past decade or two that technology has enabled immunologists to have a precise count of the different immune cells functioning under varying circumstances. World-renowned immunologist Dr. Gustav J.V. Nassol of the Walter and Eliza Hall Institute of Medical Research at Royal Melbourne Hospital in Victoria, Australia, summarizes the amazing role of the immune system: "The task confronting the natural defense system can be capsulized in six key words: encounter, recognition, activation, deployment, discrimination and regulation." Foreign or harmful cells and substances are targeted (encountered) by immune cells which do not know in advance what they will be asked to recognize. The immune cells are then activated to respond and trigger an elaborate multifaceted defense (deployment) strategy to rid the body of the invading agents or microorganisms, all the while discriminating between the pathogen and the body's own tissues so as not to render any unwanted harm. Finally the immune system participates in its own regulation to gauge the amount of response necessary to provide adequate protection for the body.

And now, the pathways along which the human mind makes its registrations on physiology are being probed more deeply than ever before. A biology of the emotions is coming into view.

These facts fit in with the final article written by Franz Ingelfinger as editor of the *New England Journal of Medicine* in which physicians were reminded that 85% of human illnesses are within the reach of the body's own healing system. Hence the importance of the expanding knowledge about the way mind and body can collaborate in meeting serious challenges.

Understandably, many physicians are apprehensive about the way this new knowledge is being misused or heralded. They perceive, and rightly so, a danger that a wide door can be opened through which all sorts of exotic and untested ideas can pass as substitutes for competent medical care. While guarding against such dangers, it is nonetheless important, as one physician said, to maintain a balanced view, one that rules out extravagant and unscientific approaches, but which at the same time fully comprehends the interactions of mind and body.

The new term, psychoneuroimmunology, has come to be descriptive of these complex interactions — interactions between the nervous system, the endocrine system, and the immune system. Now that the various other systems of human beings have been discovered and described — all the way from the circulatory system to the automatic nervous system — the system of interactions is being charted. In that system, every action or event has an effect on the totality.

Out of the wide new research, a much clearer picture is emerging of the way ideas, emotions, experiences, and attitudes can create biological change. Some patients, just in anticipating chemotherapy, will experience severe nausea and all the other adverse reactions associated with the actual taking of the drug. Shouts of fire in a crowded

auditorium can produce a wide range of physiological effects, including constriction of blood vessels and catecholamine surges capable of causing blood pressure changes and even rupturing the muscle fibers of the heart.

At times our physiological reactions may be less readily apparent than at others, but they are no less significant. It is well known, for example, that accountants, as the tax deadline approaches, experience elevated cholesterol levels. The same changes take place in many students as they approach their final examinations. Immunologist Dr. Ronald Glaser and psychologist Janice Kiecolt-Glaser, of the Ohio State University College of Medicine — giants in the new area of psychoneuroimmunology — have found that medical students, as examinations approach, will experience reduced disease-fighting immune cells and detrimental changes in other components of the immune system.

The Glaser/Kiecolt-Glaser team has also observed immune impairment in individuals enduring chronic stress. In one study, 34 family caregivers of Alzheimer's Disease victims were compared with 34 control subjects.

Positive emotions might provide a "buffer" against the immunologic effects of stress.

Caregivers had lower percentages of total T-cells, helper T-cells, and helper/suppressor (T-cell) ratios, as well as higher antibody titers to the Epstein-Barr virus (implying poorer T-cell control over the virus) than comparison subjects. Correspondingly, the more closely the caregiver associated with the victim, the lower was his or her percentage of NK cells. However, caregivers involved in a support group (in spite of having been caregiving for longer periods of time) felt substantially less lonely and had significantly higher percentages of NK cells than those not involved with a support group.

In another study of chronic stress, Drs. Kiecolt-Glaser and Glaser compared 38 married and 38 separated/divorced women. The researchers found that women who had been separated or divorced were more depressed, and had lower percentages of NK cells, less immune stimulability, and higher antibody titers to latent viruses. A subset of women who had been more recently separated (a year or less) also showed more disadvantageous percentages of helper T-cells. Even the quality of the marital relationship in women who were married was reflected in their immune status. Comparable results were found in a study of the effects of marital separation on immunity in men.

The Glasers have also demonstrated that the reduction of stress or the enhancement of positive emotions can have the effect of boosting immunity. In studying a group of elderly individuals over a period of a month, they found that relaxation training three times a week significantly increased NK and T-cell activity, with corresponding decreases in antibodies for the herpes simplex virus and in self-reported intensity of stress symptoms. The participants receiving only social contact or no contact did not experience the same benefits.

Drs. Glaser and Kiecolt-Glaser also measured the effects of relaxation training on the immune systems of medical students undergoing examination stress. Although students in both the relaxation and non-relaxation groups exhibited stress-related declines in some immune function, more frequent relaxation practice produced an increase in helper T-cells. Unlike the relaxation group, the non-relaxation group reported significant increases in anxiety and other symptoms of distress.

Taken together, these two studies suggest that positive emotions might provide a "buffer" against the immunologic effects of stress — possibly reducing the risk of disease.

Obviously, psychological factors are important in physician communication. Patients who are devastated emotionally by a diagnosis are hardly ideal subjects for urgent treatment. Does this mean that the physician must conceal or alter his findings in talking to patients? Certainly not. As I emphasized earlier, what it does mean is that the physician's communication skills may be hardly less important than his other abilities in creating a stage for effective treatment. The physician who is able to connect a sense of challenge instead of a grim forecast to a serious disease and who is able to mobilize the patient's own resources as part of a total strategy of treatment may actually be getting the most out of medical science. However serious the disease, the wise physician works with the will to live and the hopes of the patient to no less an extent than he does with particularized therapies. Two thousand years ago, Seneca observed that "it is part of the cure to wish to be cured."

What is encouraging is that, little by little, medical schools are placing increasing value on the humanities. President Derek Bok, of Harvard, had made a major educational issue out of the need for greater emphasis on the liberal arts. He has argued cogently for the fact that anyone who makes a profession out of treating people should have some idea concerning human nature, human culture and human history. His voice has been having a useful effect far beyond Cambridge.

* * *

Few things are more interesting about medical students than the way they change from the time they make their decision to select medicine as a career and the time they hang out their shingles as physicians.

Obviously, the fact of economic opportunity is no more absent, nor should it be, from such decision-making than for other professions. But altruism bulks large nonetheless with entering medical students. They want to be of service to their fellow human beings; the Schweitzer ethic, knowingly or unknowingly, is strong.

A high sense of purpose, however, comes under increasing pressure through sheer physical ordeals. Internship is the most strenuous period of all. The very qualities that are most desirable in physicians — compassion, understanding, moral commitment — are difficult to sustain under the physical hardships that are common in hospital training.

During my years at UCLA, I have been privileged to visit medical schools and hospitals in various parts of the country, meeting with students and physicians at various stages in their training and their careers. The weakest link in the entire chain of physician training, it seems to me, may be the ordeal known as the internship. More specifically, I refer to the theory that it is necessary to put medical school graduates through a human meat grinder before they can qualify as full-fledged physicians. Working around the clock — and sometimes 32 hours straight — is a common expectation of interns. The rationale seems to be that anyone who wants to go into the medical profession must be given a rigorous and systematic exposure to the realities of the physician's life.

It is reasonable to ask how the internship prepares the physician for the "realities." What if the "preparation" has the effect of dulling the sensitivities of the physician? What if it fosters feelings of resentment by an intern toward a patient who has a propensity for experiencing his sharpest pains at 3 a.m.? What kind of judgment or scientific competence can be expected of a physician who hasn't had any sleep for 32 hours? Studies of the effects of sleep-deprivation emphasize the hazards of treating seriously ill patients under circumstances of extensive fatigue. Is the excessively heavy workload not so much a sampling of later challenges as it is an exercise in what I can describe only as disguised hazing at best and systematic desensitization at worst? Is any significance to be attached to the fact that the most articulate defense of the practice came mostly from those who, having survived the experience, seemed determined not to permit others to escape? For the most part, however, I found that the large majority of physicians, on or off hospital staffs, saw little justification for the practice and, indeed, expressed serious reservations about it. They attribute the long working hours to the economic policies and concerns of hospitals.

Some of the most productive discussions I had about the institution of the internship were in the open forums accompanying the grand rounds to which I was invited by various hospitals. Not infrequently, the subject of physician-patient relationship during the internship would come up. It was recognized that the physician should make a special effort to win the patient's full confidence as well as to promote confidence by the patient in his own healing system. A compassionate attitude was described as a good way of reaching the patient.

It was at this point, however, that the discussion would break wide open. Some physicians contended that internship didn't generate feelings of compassion towards patients. They pointed out that treating patients under conditions of pressure and fatigue is no more satisfying for the physician than it is for the patient.

To what extent are the burdens placed on interns more hazing than conditioning?

Against this viewpoint was the argument that having a patient with a bloodstained knife come at you in the emergency room is enough to quiet the compassionate urgings in most doctors' souls. Another physician said he was ashamed to admit that he hoped (generally at 3 a.m.) that his call-button-pressing patient would die before he got there. Compassion, apparently, is favored by circumstance.

Over and above these specific problems is a matter I mentioned a moment ago: To what extent do the burdens placed on the interns come more under the heading of hazing than conditioning? Is a harsh and punitive attitude by some residents toward interns an essential part of the training of young physicians? Is it possible that some residents enjoy and exploit their power over the newcomers? Does hazing of this sort reflect credit on the profession? Is it really necessary?

There is the counter-argument that young doctors need to be trained to function under difficult circumstances. They must be prepared in private practice to be awakened at 3 a.m., in order to treat a patient in emergency condition. A great many hardships

continued on page 594

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Carcinogenesis, Mutagenesis, Impairment of Fertility — A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy — Teratogenic Effects — Pregnancy Category C — Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers — Studies conducted in lactating women have shown that < 0.1% of the administered oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations. Caution should be exercised when administering nizatidine to a nursing mother.

Pediatric Use — Safety and effectiveness in children have not been established.

Use in Elderly Patients — Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among reported adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs < 0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic — Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L) and, in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular — In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS — Rare cases of reversible mental confusion have been reported.

Endocrine — Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic — Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental — Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity — As with other H_2-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been reported. Because cross-sensitivity in this class of compounds has been observed, H_2-receptor antagonists should not be administered to individuals with a history of previous hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other — Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported.

Overdosage: Overdoses of Axid have been reported rarely. The following is provided to serve as a guide should such an overdose be encountered.

Signs and Symptoms — There is little clinical experience with overdosage of Axid in humans. Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

Treatment — To obtain up-to-date information about the treatment of overdose, a good resource is your certified regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the *Physicians' Desk Reference (PDR)*. In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient.

If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance.

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The Uninsured: A Lack of Realpolitik

By William J. Marshall, MD
President of the OSMA

The German word, *realpolitik,* translates as the politics of realism. A proponent of *realpolitik* does not ask what is right or what is popular, rather what is possible in a given situation. I believe we may need to adopt this attitude when dealing with the issue of America's 37 million uninsured. Despite the fact that we will spend this year over $2,000 per capita on health care — more than any other nation in the world — we still have a growing number of citizens without health insurance. I personally believe that it does not matter what we spend; costs will continue to rise until we have accepted public policy to guide how we spend our health-care dollars. We need a *realpolitik.*

How did we get this far with an unfocused public policy? Our health-care financing is a hodgepodge of public and private entitlement systems that grew out of Depression-era conditions. It began with the enactment of the Social Security Act, followed by unemployment insurance, employer-financed health insurance, and finally Medicare and Medicaid. The proponents of this patchwork system — government and labor — intended for it to be universal. However, had this goal been realized, we would not have a problem today.

A major factor affecting public policy in this country is popular sentiment. For the past decade, public opinion polls have been that Americans are concerned about access to care. Gallup reported an increase from 15% to 21% between 1976 and 1987 in the number of people with insufficient funds to pay for their health care. Thirty-six percent of the public reported that the cost of medical care often prevented them from going to the doctor or buying medicine in 1987, up from 27% in 1981. Americans are concerned about the uninsured. In 1987, 73% favored a constitutional amendment guaranteeing every American "a right to *adequate* health care if he or she cannot pay for it."

> ***"What we need in Ohio is a return to basic principles . . . We must define an adequate level of care . . ."***

Although the problems of the uninsured are generic in this country, I would like to focus on these issues in Ohio. Our state has 1.4 million uninsured, of whom over 400,000 are children. Medicaid has failed to keep pace with the increase in the number of people below the poverty level. Currently, Ohio is facing a $44 million shortfall in funding for hospitals in the Medicare program. Physicians' services also continue to be underpaid despite small fee increases in the past year. Medicaid is looking to implement a prospective outpatient payment system in 1989. The Ohio Legislature has been debating mandated health-care benefits. The rising cost of insurance coverage has kept some businesses from providing health insurance. Over 600 state-mandated benefit laws across the country are playing an important role in the ever increasing costs of coverage. These mandated benefits include coverage

of services for more than 140 allied health professions in addition to the traditional services of physicians. Included are naturopathic, psychologic, optometric and chiropractic services, as well as acupuncture and acupressure. Adding to the above the coverage of patients with drug addiction, alcoholism and immune deficiency disease, it is not difficult to understand why insurance has become unaffordable for so many.

There are currently several proposals to aid the uninsured in the Ohio Legislature. Legislation has been introduced in the House of Representatives to establish a program similar to the Canadian health system. The Legislature is also considering legislation to establish state risk pools for the uninsurable and five pilot programs for the working uninsured. The plain truth is, however, even should all these bills pass, our problems will still remain.

The answer doesn't lie in totally dismantling our present health-care system in favor of a new one. What we need in Ohio and the country as a whole is a return to basic principles, recognizing that our resources are finite and that continuing to pour more money into the system will not change anything. We must confront the reality of rationing. We must define an *adequate* level of care to

continued on page 594

Principles for Health-Care Resource Allocation

(Adopted by the 1988 Citizens Health-Care Parliament, September 23-24, 1988 in Portland, Oregon)

Purpose of health services

(1) The responsibility of government in providing health-care resources is to improve the overall quality of life of people by acting within the limits of available financial and other resources.
(2) Overall quality of life is a result of many factors, health being only one of these. Others include the economic, political, cultural, environmental, aesthetic and spiritual aspects of a person's existence.
(3) Health-related quality of life includes physical, mental, social, cognitive and self-care functions, as well as a perception of pain and sense of well-being.
(4) Allocations for health care have a claim on government resources only to the extent that no alternative use of those resources would produce a greater increase in the overall quality of life of people.
(5) Health-care activities should be undertaken to increase the length of life and/or the health-related quality of life during one's life span.
(6) Quality of life should be one of the ethical standards when allocating health-care resources involving insurance or government funds.

Why priorities need to be set

(7) Every person is entitled to receive adequate health care.
(8) It is necessary to set priorities in health care, so long as health-care demands and needs exceed society's capacity or willingness to pay for them. Thus an "adequate" level of care many be something less than "optional" care.

How to set health priorities

(9) Setting priorities and allocating resources in health care should be done explicitly and openly, taking careful account of the value of a broad spectrum of the Oregon populace. Value judgments should be obtained in such a way that the needs and concerns of minority populations are not undervalued.
(10) Both efficiency and equity should be considered in allocating health-care resources. Efficiency means that the greatest amount of appropriate and effective health benefits for the greatest number of persons are provided with a given amount of money. Equity means that all persons have an equal opportunity to receive available health services.
(11) Allocation of health-care resources should be based, in part, on a scale of public attitudes that quantifies the tradeoff between length of life and quality of life.
(12) In general, a high priority health-care activity is one where the personal and social health benefits/cost ratio is high.

Who sets what priorities

(13) The values of the general public should guide planning decisions that affect the allocation of health-care resources. As a rule, choices among available alternative treatments should be made by the patient, in consultation with health-care providers.
(14) Planning or policy decisions in health care should rest on value judgments made by the general public and those who represent the public, and on factual judgments made by appropriate experts.
(15) Private decision-makers, including third-party payors and health-care providers, have a responsibility to oversee the allocation of health-care resources to assure their use is consistent with the values of the general public.

United Effort = Success

OSMA Auxiliary's Commitment to the Future

By Barbara Marshall

One of the highlights of any OSMA Annual Meeting for a medical school dean is the presentation of AMA-ERF checks. Two checks are usually presented to each school: one from the Medical School Excellence Fund for unrestricted use; the other from the Medical Student Assistance Fund restricted to the school's program of financial assistance. An official of one Ohio medical school indicated in a recent thank-you letter that funds received this year would be used to support the Student Financial Assistance Program and to help plan and effect changes in the curriculum.

The American Medical Association Education and Research Foundation was established by the AMA Board of Trustees almost 40 years ago to help support quality education in the nation's medical schools. In 1953, the AMA Auxiliary joined the AMA in this effort, making AMA-ERF its sole, national philanthropic endeavor. Through combined efforts, AMA-ERF has grown to become the major philanthropy of organized medicine. Since its inception, the foundation has distributed over $48 million in gifts nationally to medical schools; guaranteed over $95 million in loans benefiting more than 40,000 medical students, interns and residents; and supported numerous research projects.

AMA-ERF is a major focus of the OSMA Auxiliary, with constituent counties raising funds in a variety of ways. One of the most effective vehicles is the holiday sharing card, which is sent to every member of a medical society to express holiday greetings from physicians and Auxilians who have contributed to AMA-ERF in lieu of sending individual cards.

To quote some recent statistics, from 1985 to 1989 Ohio's contributions to AMA-ERF totaled $347,162. Of that amount $255,037 was contributed through the OSMA Auxiliary. Nationally, this year's medical family raised a total of $1,872,247.91 for AMA-ERF. Of that total, $1,523,664.27 was raised through Auxiliary efforts. (Physicians contributed $348,583.64.)

In addition to these efforts, most county auxiliaries continue their support for medical education through their own scholarship or loan funds. Some have established endowments to provide financial aid to future students.

The OSMA Auxiliary continues to demonstrate its commitment to quality health care for tomorrow by supporting quality medical education today. **OSMA**

Barbara Marshall is President of the OSMA Auxiliary.

From the Editor . . . *continued*

a look at this surprising new-old problem.

Also in this issue: Part II of our guest editor Norman Cousins' article, "Learning from Medical Students," can be found under the new "Guest Editor" head . . . and this month, Columbus cardiologist Richard Lewis, MD, initiates another new *OHIO Medicine* column, "Clinical Capsules," which will examine the latest news in a given specialty each month. Also, don't miss our "Ohio Medi-scene section" . . . there are some great stories this month, everything from the hazards of radon to Cleveland's well-orchestrated public relations comeback — which rides on the success of that city's medical community. Just how successful a comeback can the much-maligned city-on-the-lake make? Read the piece, then, like our lead stories, feel free to draw your own conclusions . . .

Karen S. Edwards

Next month in OHIO MEDICINE

- **Ohio's Fel Study**
- **Medical Videos**
- **Laser Medicine**

OSMA Councilors

Listed below are the OSMA Councilors and the districts they represent. If you have any questions or concerns regarding OSMA, please address them to your Councilor.

First District
Stanley J. Lucas, MD
2905 Burnet Avenue
Cincinnati, Ohio 45219
Adams, Brown, Butler, Clermont, Clinton, Hamilton, Highland, and Warren

Second District
Walter A. Reiling, Jr., MD
2200 Philadelphia Drive, Suite 548
Dayton, Ohio 45406
Champaign, Clark, Darke, Greene, Miami, Montgomery, Preble, and Shelby

Third District
William H. Kose, MD
200 W. Pearl Street
Findlay, Ohio 45840-3713
Allen, Auglaize, Crawford, Hancock, Hardin, Logan, Marion, Mercer, Seneca, Van Wert, and Wyandot

Fourth District
Su-Pa Kang, MD
3900 Sunforest Court, Suite 104
Toledo, Ohio 43623-4498
Defiance, Fulton, Henry, Lucas, Ottawa, Paulding, Putnam, Sandusky, Williams, and Wood

Fifth District
Henry G. Krueger, MD
24700 Lorain Road
North Olmstead, Ohio 44070
Ashtabula, Cuyahoga, Geauga, and Lake

Sixth District
Robert C. Reed, MD
985 Sawberg Avenue, NE
Alliance, Ohio 44601-3590
Columbiana, Mahoning, Stark, and Trumbull

Seventh District
Nermin D. Lavapies, MD
1220 Hughes Avenue
Martins Ferry, Ohio 43935
Belmont, Carroll, Coshocton, Harrison, Jefferson, Monroe and Tuscarawas

Eighth District
John F. Kroner, Jr., MD
Box 708
Athens, Ohio 45701
Athens, Fairfield, Guernsey, Licking, Morgan, Muskingum, Noble, Perry, and Washington

Ninth District
Richard Villarreal, MD
613 Center Street
Wheelersburg, Ohio 45694-1795
Gallia, Hocking, Jackson, Lawrence, Meigs, Pike, Scioto, and Vinton

Tenth District
Claire V. Wolfe, MD
5521 Indian Hill Road
Dublin, Ohio 43017
Delaware, Fayette, Franklin, Knox, Madison, Morrow, Pickaway, Ross, and Union

Eleventh District
Charles G. Adams, MD
5896 Liberty Avenue
Vermilion, Ohio 44089
Ashland, Erie, Holmes, Huron, Lorain, Medina, Richland, and Wayne

Twelfth District
Jack L. Summers, MD
75 Arch Street
Suite B2
Akron, Ohio 44304
Portage and Summit

The Uninsured . . . *continued*

which all of our citizens should have access.

A thoughtful and thorough study of these issues has been accomplished in Oregon. It dealt with the problem facing us at this moment: how to fairly allocate limited health-care dollars. The year-long study culminated in a day and a half of intense discussion and debate by individuals (24) who participated in community meetings, appointees (five) of county commissions, and representatives (11) of citizen groups with an interest in health issues. The result of this meeting was a list of 15 public policy principles intended to be guideposts for state legislatures, insurance companies and others concerned with health-care resource allocation.

I support, and I hope you agree, it is time for Ohioans to develop a *realpolitik.* **OSMA**

Medical Students . . . *continued*

come with the medical franchise and need to be incorporated into medical education. A physician friend of mine said he could understand how I would be appalled by some of the things I saw but most physicians seemed to survive internship quite well and, indeed, felt the better for it.

I gave full weight to these facts, of course, but I was encouraged nonetheless by the changes that were beginning to emerge in internship policies. Some hospitals were leading the way in humanizing the training of interns. I am especially encouraged by the efforts of the Family Practice and Pediatrics divisions of the UCLA Medical Center to design working conditions for interns that were as much in the interests of the patients as in the interests of the young physicians. **OSMA**

COLLEAGUES

JOSEPH SOPKO, MD, Cleveland, has been appointed by Gov. Richard Celeste to the newly established Ohio Respiratory Care Board . . . **HARRY HORWITZ, MD,** Cincinnati, was honored at the Swordsman's Ball, an annual fund-raiser for the American Cancer Society, for his contribution to oncology . . . **NORMAN BASH, MD,** Cleveland, has been named director of physician affairs at Meridia Hillcrest Hospital . . . **STEVEN N. BASS, MD,** Cleveland, has been appointed director of the internal residency program at Saint Luke's Hospital . . . **HOWARD SUDAK, MD,** Cleveland, has been elected the second president of the American Suicide Foundation . . . **JYOTI DEORAS, MD,** Akron, has been named medical director of the Margaret B. Shipley Child Health Center . . . **JOHN J. NEWTON, MD,** Sylvania, has been appointed to the Lucas County Mental Health Board . . . **CASS CULLIS, MD,** Troy, has been elected president of the newly formed Miami County Division of the American Heart Association . . . **KENNETH K. KLINE, MD,** Lancaster, has been elected president of the Fairfield County Academy of Family Physicians . . . **JANET M. BLANCHARD, MD,** Mentor, has been elected president of the Lake County Medical Society for 1989 . . . **RAY O. NULSEN, MD,** Russells Point, and **BONG OH KIM, MD,** Bellefontaine, have been honored by the OSMA for 50 years of medical service . . . **PAUL GUENTHER, MD,** Ft. Thomas, has been named president of the medical staff at Booth Memorial Hospital . . . **PAUL R. ZEIT, MD,** Burton, has been named Cleveland region medical director of the Chicago-based Parkside Health Management Corp. . . . **RICHARD SCHLANGER, MD,** Dublin, has been appointed cancer liaison physician at Saint Anthony Medical Center . . . **GREGORY O'BRIEN, MD,** Garfield Heights, has been named chairman of the division of surgery at Marymount Hospital . . . **DAVID P. LOSH, MD,** Toledo, has been named director of the W.W. Knight family practice residency program at Toledo Hospital . . . **G.B. BLOSSOM, MD,** Maumee, has been appointed medical director of Parkwood Physicians Center . . . **MICHAEL BRADY, MD,** Columbus, has received a 1989 Director's Service Award from the Ohio Department of Health for medicine, social work, education and volunteer service related to AIDS . . . **CHARLES J. MILLER, MD,** Akron, and **N. RAY BAUMGARTNER, MD,** Cincinnati, have both received the Ohio State Radiological Society's highest honor, the Silver Medal . . . **JAMES M. BAZZOLI, MD,** Marion, was one of two recipients of the AMA National Congress on Adolescent Health Award for Distinguished Service on Behalf of America's Youth By a Practicing Physician . . . **RONALD L. PRICE, MD,** Cleveland, has been installed as the 88th president of the Academy of Medicine of Cleveland

Ronald L. Price, MD

. . . The Jewish Hospital in Cincinnati has renamed the hospital's laser center to honor the center's former medical director and the "Father of Laser Medicine," **LEON GOLDMAN, MD,** La Jolla, California . . . **ERIC C. LUESSEN, MD,** Blue Ash, has been appointed medical director of the pain center at The Jewish Hospital . . . **GARY L. GILLEN, MD,** Circleville, and his wife, Cynthia, have received the Environmentalist of the Year Award from the group ACTION, Activists Concerned With Toxics in Our Neighborhoods, for their work in helping to improve, monitor and protect the health and quality of life in Pickaway County . . . **ANTOINETTE P. EATON, MD,** Columbus, has been elected the first woman president of the Academy of Pediatrics for 1990-91.

LETTERS TO THE EDITOR

To the Editor:

As I was reading "The Ohio State Medical Board: Is It Doing Its Job?", and read the side box insert on Board budget, I became distraught. The same mentality and "logic" that has produced a "malpractice and bad result fund" by assessing the limited number of physicians at a larger dollar amount for the protection of the American public at large now states through the actions of Governor Richard Celeste and Representative James Campbell that the physicians should have a "tax" increase of 34%-60% in licensing fees to "provide for the general welfare" of the state of Ohio, which is the Board's fourth and fifth charge.

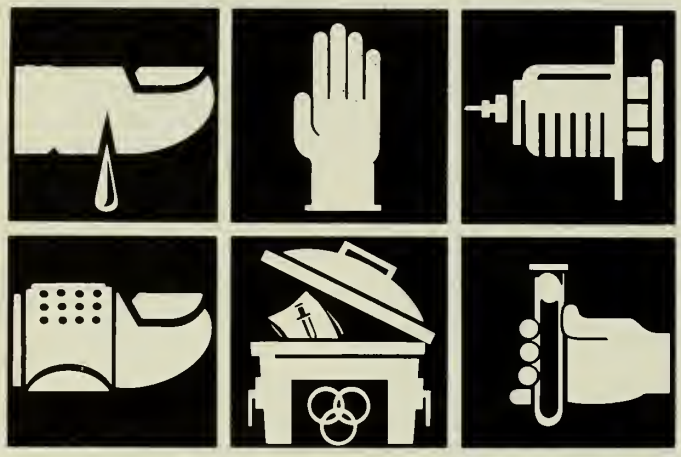
Physicians have long accepted this type of logic by the statement that we are professionals, fiduciary in nature, and we accept responsibility to provide the best care possible for our patients.

Deep inside of me, I feel that this logic is somehow wrong and those who foster it need a course in remedial logic.

Sincerely,
Brady B. Stoner, MD
Cambridge

OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians



AIDS vaccine study begins in England

The safety of a new AIDS vaccine, known as HGP-30, is currently being evaluated in London, England.

The trial will take place at St. Stephen's Hospital and will enroll 24 healthy volunteers who have tested negative for AIDS. An additional 24 volunteers, who will not receive the vaccine, will serve as controls.

According to Allan Goldstein, Chairman of the Department of Biochemistry and Molecular Biology at George Washington University School of Medicine, Washington, D.C., "HGP-30 is designed to overcome two of the major barriers to producing a successful protective vaccine. First, it is a synthetic copy of the p17 gag structural protein. Unlike the envelope of the AIDS virus, this region is more 'conserved' and does not appear to change from strain to strain through a process called 'genetic drift.' If successful immunization is achieved, an individual should be protected from all of the various strains of the AIDS virus. Second, because it is a totally synthetic molecule containing no live virus, HGP-30 will not, itself, cause infection."

Initial in vitro studies using human cells have shown that HGP-30 stimulates the production of antibodies that destroy the ability of several strains of the AIDS virus to replicate. Animal studies have shown HGP-30 stimulates the production of desired antibodies without producing any toxic side effects. Most recently, it has been shown that HGP-30 can elicit potent T-cell mediated responses in vitro. Scientists generally agree that this type of immune response is critical to the development of an effective vaccine for AIDS.

Worldwide rights to HGP-30 are owned by Viral Technologies, Inc., which is providing financial and technical assistance for the project.

Children can cope with hospitals

If you've been hesitant about hospitalizing your younger patients for fear a stay may be too distressful, there is a new study out that might ease your mind.

Although doctors have assumed for years that hospitalizations causes depression in children, researchers at the Medical College of Georgia reported at a meeting of the American Psychiatric Association that hospitalized children experience no greater distress than children in the general population.

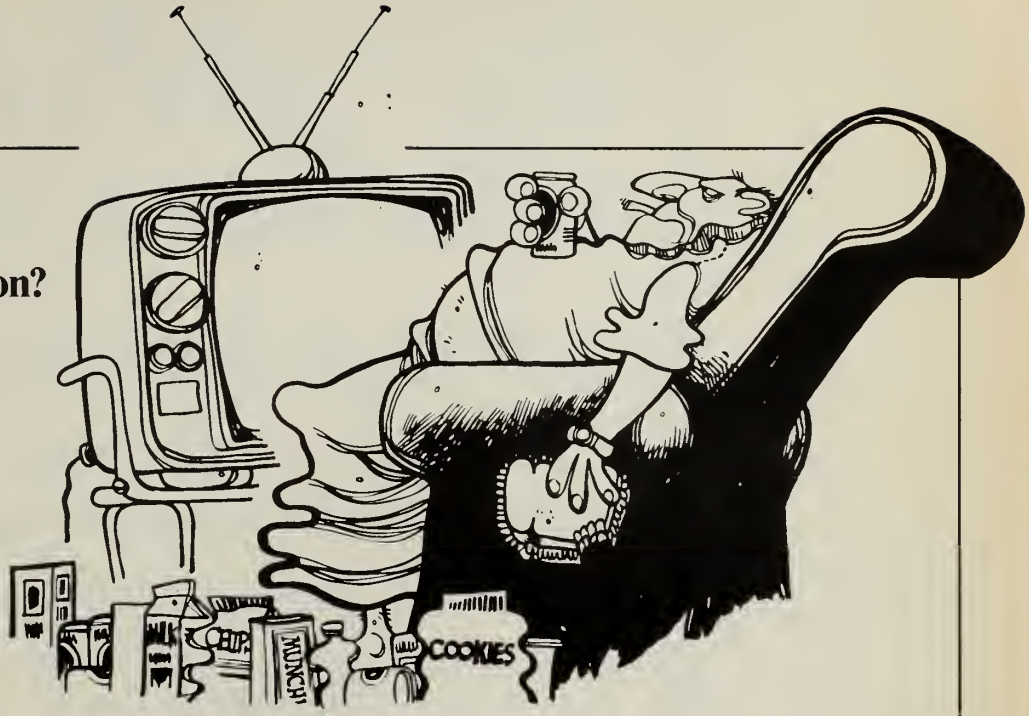
In contrast, however, 24% of the parents reported moderate to severe levels of depression, which did affect the manner in which the child was able to cope with his or her hospitalization. Children who had depressive symptoms, for example, were more likely to have mothers who were experiencing emotional distress.

The researchers offered two possible explanations for the occurrence:

1. The children use parents as an indicator, to see how depressing they should consider the hospitalization and
2. A depressed parent may be less available to provide support.

The solution? Obviously, helping parents out of a depression (perhaps by involving them actively in the child's care) will enable the child to better handle the stressful hospital environment.

Preventive medicine — new health-care direction?



Doctors are being urged to spend as much time on preventive medicine in their practices as they do in diagnosing and treating.

"The key to improved health and disease prevention often lies in lifestyle changes made by patients, rather than in the broad testing or sophisticated medical procedures performed by health providers," says Robert S. Lawrence, MD, Chairman of the U.S. Preventive Services Task Force, a 20-member panel of health-care experts appointed by the Department of Health and Human Services in 1984.

Copies of the task force's 300-page "Guide to Clinical Preventive Service" have been distributed to medical educators and medical societies, and are available in medical bookstores.

The guide recommends that doctors counsel patients to: give up smoking, prevent sexually-transmitted diseases, eat better, exercise, wear seat belts and avoid drug and alcohol abuse.

Although the report made no financial recommendations, Dr. Lawrence said insurance companies should change how they reimburse for physician services, raising what they pay for information and counseling services in relation to surgical services.

The report was accepted by HHS without comment.

Kiddie cholesterol

While the AMA is waging war with adult cholesterol, pediatricians across the country are having second thoughts about testing their patients' cholesterol levels, despite a study that suggests two-thirds of today's youngsters have a risk of heart disease that continues to go undetected.

Required testing of all school children, the report says, would allow doctors to discover which children are in the upper ranges of high cholesterol, and help families change their diet to lower the children's risk.

But mass cholesterol testing of children could spur overuse of cholesterol-lowering drugs or diets which might harm normal growth and development, pediatricians argue. Besides, they add, there is no proof that changing the diet in childhood will prevent adult heart disease.

Pediatricians currently recommend that children's blood cholesterol levels be tested only if they have a family history of early heart attacks or excess blood cholesterol. Children over two whose blood cholesterol is over 176 are generally placed on low-fat diets. Cholesterol levels above 240 are considered high for adults. — *Karen S. Edwards*

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OHIO MEDI-SCENE

Hidden health hazard . . . home health care for children . . . streaking star . . . dermatology facelift . . . Medicaid tips . . . AMA Congress on Adolescent Health . . .

Radon: the hidden health hazard

More times than not, concern about radon is outweighed by seemingly more pressing day-to-day issues. Radon is also overshadowed by other environmental issues such as air pollution, the Alaskan oil spill, hazardous waste, landfills and the safety of drinking water.

Perhaps one reason radon is so easily overlooked is because of its elusive physical qualities — radon is odorless, colorless and tasteless. Consequently, "It's hard for the public to grasp this issue," says Richard Guimond, director of the U.S. EPA Office of Radiation Programs.

But what the public might not realize is that radon is the number-one environmental health hazard today, say experts who attended a recent radon conference in Columbus. The conference was sponsored by the Ohio Air Quality Development Authority (OAQDA).

Compared to other environmental issues, "Radon far outshines the others as far as health risks," says Christine Ehaman, coordinator of the Centers for Disease Control's radon program. "The evidence is in that radon does cause cancer."

In fact, radon is thought to be the second leading cause of lung cancer after smoking. About 20,000 lung cancer deaths per year are linked to radon exposure, Ehaman reports.

OHIO MEDI-SCENE

Radon: the hidden health hazard . . . *continued*

Ehaman says she's puzzled by skepticism about the quality of data that supports these findings. One study analyzed individuals who were exposed to radon while working as underground miners in the 1950s and 1960s. Objections were raised because many of the miners were heavy smokers and all were male adults.

But Ehaman maintains that there is sufficient epidemiological data to support the link between radon and cancer. "We have not overestimated the risk," she says. In fact, "Risk is being shown at lower and lower exposures," she says.

The overall goal of environmental groups is to keep radon levels as low as possible. A current guideline for an acceptable level of radon is four picocuries per liter (pCi/1). But even at this level, the lifetime risk of developing lung cancer is one to three in 100, which is not a negligible risk, Ehaman points out.

According to a recent study, an estimated 62% to 84% of houses in Huron, Franklin, Pike and Logan counties were found to have radon levels above the four pCi/1 guideline, reports Ashok Kumar of the University of Toledo Department of Civil Engineering.

In general, the risk of lung cancer increases as the level of radon and the length of exposure increase.

According to a radon risk evaluation chart provided by the U.S. EPA, a radon level of four pCi/1 increases a non-smoker's risk of cancer by about four times. At a level of 20 pCi/1, the comparable risk is the same as smoking one and a half packs of cigarettes per day. At 200 pCi/1, the risk is the same as smoking four packs of cigarettes a day or more than 60 times that of a non-smoker.

In addition, radon appears to multiply the risk of lung cancer in those who do smoke, Ehaman says.

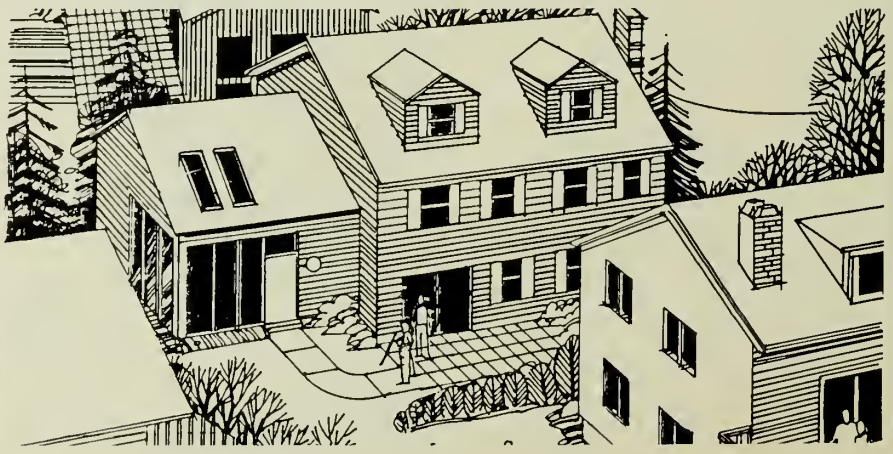
Radon occurs virtually everywhere in the U.S. "Houses are absolutely perfect radon collectors," says Guimond. Radon is diluted in outside air, but accumulates when trapped in enclosed spaces.

Indoor levels of radon depend on a building's construction and the concentration cf radon in the underlying soil. Radon can also seep in through cracks in concrete and walls, floor drains, sumps and small cracks in hollow-block walls.

Some EPA suggestions for reducing the risk of lung cancer from radon exposure include: stop smoking; spend less time in areas of higher concentration such as in basements; open windows and turn on fans to increase air flow through the house; and keep crawl spaces under houses well-ventilated.

Several of the conference experts pointed out that the radon issue is especially timely. A radon bill (House Bill 279) currently before the Ohio House proposes that radon testing be standardized and staffing for radon programs be increased.

At the same time, several statewide radon surveys are in the works. An OAQDA-funded survey will compare the long-term and short-term effects of radon on health, says Deborah Steva of the



Ohio Department of Health. These results should be released this summer, she says.

Guimond reports that the EPA plans to implement a national radon testing program for U.S. schools. In a preliminary survey of schools in 16 states, more than half were found to have radon levels above the four pCi/l standard.

The levels of radon in Ohio schools should be tested because much of central Ohio is located on uranium bearing shale, which emits radon gas, Guimond suggests.

Some of the radon levels in schools in other states were particularly worrisome. A school in Tennessee had a radon level of 138 pCi/l, while the level in a Washington school was 96 pCi/l. According to the EPA risk chart, at levels of 100 pCi/l, the estimated number of lung cancer deaths in 1,000 range from 270 to 630.

"The issue keeps getting bigger and bigger," Steva points out. "We're trying to characterize the problem in the state and determine how big it is. A large part of Ohio remains a mystery," she says. "We're trying to fill some gaps in our knowledge." — *Deborah Athy*

Program proves you *can* go home again

Critically ill children, who would normally endure lengthy stays in the hospital, may be going home early with the help of Cleveland Metropolitan General Hospital's innovative Pediatric Service Coordination Program.

The program, which is slated to begin late this summer, is designed to teach parents how to care for their sick children at home.

"The major focus is on children with complex care needs," says the program's coordinator, Lyn Cooper Gill. "We're defining it in a generic way" to include children with "extraordinary" needs. Such children may include those dependent on mechanical ventilation, those who require intravenous drugs and/or nutrition and those with a daily dependence on other support systems such as oxygen therapy and renal dialysis.

The program was developed with the help of Rainbow, Babies and Childrens Hospital, The Cleveland Clinic Foundation and Health Hill Hospital for Children, and $370,000 was donated by the Department of Health and Human Services and The Cleveland Clinic Foundation to get the program started.

In addition, six home care agencies — the Visiting Nurses Association of Cleveland, Medical Personnel Pool, Kimberly Quality Care, Hospital Home Health Services of Northeast Ohio, Home Team and Cleveland Clinic Home Care Services — will provide services for families who want to care for their children at home.

Because it is a pilot program, Gill says that only children from birth to age five will be eligible, though older children with similar needs will be considered. (Older children often have developmental needs in addition to their physical needs, Gill explains.)

Once a family is accepted into the program, a registered nurse, known as a family service coordinator, will work with the family before the child is discharged from the hospital. For about the first six months the child is at home, the nurse will help the family work with the various doctors, nurses, therapists and social workers who care for their child.

Ideally, the family will feel confident enough after six months to care for their child unaided, but if a difficult situation arises, help will only be a phone call away.

Ultimately, Gill says, about 120 families with seriously ill children will have been helped when the pilot project ends in 1991.

But, she adds, the three-year deadline on the program does not mean that it will be eliminated. On the contrary. "We're designed to end in three years, but we hope to find out what works and integrate it into our system . . . We're trying to take the best of what we have and institutionalize it.

"It would be great if (the hospitals involved) would all ultimately adopt the same procedures," she continues, "but the important thing is that they adopt what works for them."

She also adds that "This is not exclusive to families who have children in these hospitals . . . these are flagship hospitals. When we get the process up and running, we'll get primary care physicians and other hospitals" involved as well.

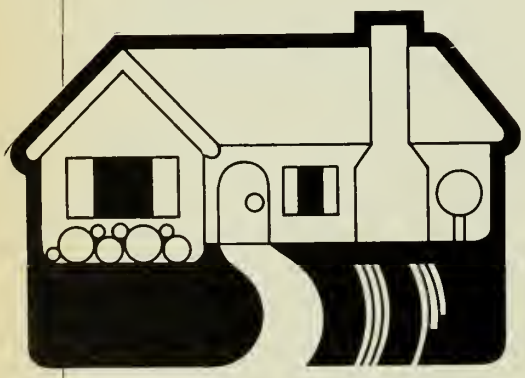
Because home care is generally less expensive than hospitalization,

OHIO MEDI-SCENE

Home care . . . *continued*

coordinators of the program are also concentrating on encouraging third-party payors, including Medicaid and private insurers, to pay for it.

Gill says that talks with Medicaid have been ongoing, but so far nothing concrete has been agreed upon. Part of the problem, she says, is determining at "what point is home care helpful to the family without being 'out of control' for the third-party payors."



Gill is hoping that providing third-party payors with data on costs once the project ends will convince insurers that home health care can indeed be cost-effective.
— *Michelle J. Carlson*

The "streaking star" on the lake

There was a time — not so long ago — when people made jokes about Cleveland. There was the one about the Cuyahoga going up in flames . . . and the one about the mayor catching on fire . . .

In many ways, Cleveland was misunderstood, explains George Miller, Executive Director of the New Cleveland Campaign. But in the last decade, Miller and others have been working to bring Cleveland's strengths out of obscurity and into the spotlight. It's about time that people realize "just what Cleveland has to offer," he says.

Working in cooperation with the Greater Cleveland Growth Association and the Convention and Visitors Bureau of Greater Cleveland, the New Cleveland Campaign was created in 1978 "to address the way Cleveland was perceived locally and nationally," Miller says.

It appears that their efforts are paying off, because Cleveland is increasingly getting "toasted" instead of "roasted." In fact, a survey in *Money* magazine christened Cleveland one of the Midwest's "streaking stars."

The city has been building a long list of accomplishments. It has been named an All-American City three times in five years . . . picked to be the home of the future Rock and Roll Hall of Fame and Museum, beating out such heavies as Los Angeles and New York City. Unemployment is down from 16.6% in 1983 to a current 7.7%. And, at last report, 17 Fortune 500 companies were calling Cleveland home.

Even the look of the city has new polish — from the enhanced downtown skyline to the renovations along the lakefront and the Flats.

Since the new Cleveland Campaign has been in operation, perceptions have gone from negative to positive, Miller says, and much of the city's negative tarnish is being erased. The word is out that Cleveland is not "the mistake on the lake" — as it was once dubbed — but a thriving city with abundant business opportunities, he says.

While Cleveland continues to garner respect for its new-and-improved attributes, the New Cleveland Campaign also wants to direct attention to Cleveland's impressive history in endeavors such as business, medicine publishing and printing.

For example, one ad in a series developed for the campaign focuses on the city's long-standing contributions to medicine. The ad points out: "Your life may have a second chance because of these firsts." These Cleveland "firsts" include medical innovations such as X-rays, amniocentesis, CAT

scan, kidney dialysis and coronary angiography.

The health-care aspect is very important to the city, Miller points out. "It's not only a service to the city but an economic presence as well. Health care is a major segment of the area's job bank."

According to Greater Cleveland Hospital Association (GCHA) estimates, the health-care industry employs nearly 100,000 people in the Cleveland area, with the Cleveland Clinic Foundation being the city's largest private employer.

"This area is responsible for the education and training of a great many people in the country and all over the world. We want to elevate awareness about the uniformly high quality of health care" in Cleveland, he says.

One ad points out: "Your life may have a second chance because of these firsts."

The health-care ad and others are scheduled to appear in nationwide publications including *The Wall Street Journal, Forbes, Business Week* and other trade magazines. Other ads in the series highlight other Cleveland bright spots, including education, business, real estate, the waterfront and sports.

The New Cleveland Campaign hopes to send a positive message about Cleveland not only nationwide, but also to Clevelanders themselves. "They're our own best ambassadors," Miller says. "We needed to raise their confidence and awareness of the city."

Miller plans to conduct a survey in the near future to determine if people are starting to look at Cleveland in a new light. Miller, for one, hopes the time has come for Cleveland to have the last laugh. — *Deborah Athy*

Field of dermatology getting a facelift

The field of dermatology may be getting older, but it's not necessarily getting better. So say some medical researchers, who think that scientific research in dermatology is lagging when compared to other fields of medicine.

"So often what goes on in dermatology is sophisticated cosmetology instead of science," says David R. Bickers, MD, director of dermatology at University Hospitals in Cleveland. "That is one of the problems that has bedeviled dermatology: The basic science has lagged behind other fields of medical research, such as the investigation of the heart or lungs."

That trend may change, however, now that University Hospitals and Case Western Reserve University has been designated by the National Institutes of Health as one of two (the other is New York University) federally funded research centers devoted to skin diseases research.

The $1.2 million grant, says Angela Welsh, the program's administrator, is for five years, and is significant because "This is the first time the government has supported on this scale . . . research on skin diseases.

"Most people view our skin as just the outside of us, our appearance," she continues. "The issue is that skin diseases are generally not life-threatening, so they haven't been approached with the same urgency as other diseases."

"It's long overdue," adds Dr. Bickers, who serves as director of the center. "The advances seen in other areas of medicine can now happen in dermatology. As our research activities expand, laboratory work will lead us to new treatment for patients in the shortest amount of time."

Scientists at the center are currently studying the skin at the cellular and molecular levels in an attempt to better understand the aging process, skin cancer and the skin's role in the body's immune system. Their research, says Dr. Bickers, may someday allow physicians to develop a more rational, therapeutic approach to treating skin diseases.

"As an example, the whole issue of how Retin-A is being used brings this into focus," says Dr. Bickers. "Retin-A has received Food and Drug Administration approval only as an acne treatment, not as a wrinkle eraser. There's nothing wrong about it being used for that, but the fact is, not enough research has been done on how it works or on the long-term effects of rubbing it into your skin."

Researchers are also studying the effect of sunlight and chemicals in the environment on the skin and why some people may be more susceptible to skin cancer than others.

"Skin has the ability to transform chemical compounds into helpful or harmful substances," Dr. Bickers explains. "By understanding the mechanism by which this occurs, we may be

OHIO MEDI-SCENE

Dermatology ... *continued*

able to custom design a sunscreen that can block the sun's rays as well as inhibit the skin's ability to induce a toxic change." Other areas to be explored include:

- Using a staining technique that makes patterns or "fingerprints" of the skin to predict changes in skin diseases.
- Introducing mutant genes into transgenic mice to examine the effect on skin physiology, differentiation and development.
- The production of collagen in fibroblast cells and their role in aging in collagen-rich tissue such as the skin, lungs and joints.

Because scientific research in the field of dermatology has been paralyzed for so many years, Dr. Bickers warns that results may be slow in coming. Still, he is encouraged that the center has been developed at all.

"The advances seen in other areas of medicine can now happen in dermatology."

"We see this as an opportunity to create a world-class research center with the potential of making lasting contributions," he says. "Each time we learn something about the skin, it triggers something else. We want to push back the frontiers of skin research." — *Michelle J. Carlson*

Medicaid tips

The Ohio Department of Human Services makes changes in the drug formulary quarterly. Most of the additions and deletions are based on recommendations presented by the Pharmacy and Therapeutics Committee. The committee is composed of Janet Bixel, MD; Charles May, DO; James Visconti, PhD; Suzanne Eastman, RPh, MS; Mary Ann Waltenbaugh, RN; and Robert P. Reid, RPh, Chairman. For your information the following changes will appear in the August 1, 1989 update:

Trade Name Additions — New Drugs

Aquasl E Drops; Calciferol Inj, Liq; Cardene 20mg, 30mg; Cardizem SR 90mg, 120mg; Cyclomydril Drops; Cytotec; Eulexin; Hismanal; Metrogel; Minitran; Nolex LA; Norzine Tab, Inj, Supp; Orap; Oxistat; Prinzide; Pyrazinamide; Trancopal; Uro-Mag; Zestoretic.

Trade Name Additions — Line Extensions

Beclovent; Beconase; Betagan; DDAVP; Desyrel 300mg; Fungizone Lot, Oint; Imodium AD; Intron A 50mmu; Lactrase 250; Levsin S/L; Lupron Depot; Mevacor 40mg; Mykrox; Nebcin; Neptazane 25mg; Platinol AQ; Propine; Questran Light; RMS 30mg; Roferon A 36 mmu; Rynatan-S; Somophylin DF; Tegretol Susp; Ventolin Rotocaps; Zestril 40mg.

Generic Additions

ACTH Gel; Atropine 0.0; Bacitracin/Polymixin Oint; Cefadroxil; Cytarabine Inj; Dexpanthenol Inj; Dextrose w/Potassium; Dextrose; Dextrose Fifth Saline; Dextrose 50, 100 ml; Dicyclomine Inj; Ferrous Fumarate/Docusate; Fluocinonide Gel, Soln; Gentamicin Inj w/Diluent; Guaifenesin CF, PE; Leucovorin Calcium 5 mg; Lidocaine Oint; Methylprednisolone 16 mg, Inj 80 mg; Milk of Mag w/Cascara; Oxycodone/Aceta 5/500; Pentamidine 150 mg, 300 mg Reconstituted; Triamcinolone Dental Paste; Vitamin Infant 0.25 mg Fluoride; Warfarin (PBI only).

Generic and Trade Deletions

Balsaderm; Chlormezanone; Dermuspray; Dramamine Inj (Some); Flagy IV (Some); Granumed; Stimuzyme Plus; Combipres (MAC); Microx (Now Mykrox); Pediacare (DC NDC); Uniphyl 200 (Now T-PHYL).

Generic and Trade Deletions (Desi)

Bellergal-S; Chlorphen/P-Prop/Pheyleph; Decongestabs; Decongestant; Donnazyme; Entex Cap, Liq; Hemorrhoidal HC; Naldec; Naldecon; Naldelate; New Decongestant; Pediacof; Phentox; Phenylprop/Guai/P-EPH; Pramosone; Pramoxine HC; Proctocream HC; Proctofoam HC; Pyridium Plus; Quadrahist; Rutuss, HC; Tri-Phen-Chlor; Uni-Decon. — *Robert P. Reid, RPh and Janet Bixel, MD*

Second Annual AMA Congress on Adolescent Health

From May 19 to May 21, 1989, it was my privilege to be among the participants at the Second Annual AMA National Congress on Adolescent Health. President-Elect Sue Massie and I attended all the plenary sessions and workshops, attempting to cover all facets when there was more than one topic being offered at the same time.

This Congress and the one last year grew out of the results of the White Paper on Adolescent Health that the AMA produced in December of 1986. It presented the statistics on the morbidity and mortality rates of today's teens, who should be experiencing what has long been viewed as the "golden opportunity." Shifts in social and economic phenomena have affected teens of all levels of society. It was made clear that there are mentally ill adolescents as there are mentally ill adults and that distressed families may produce teens with emotional problems. By and large, however, the ordinary teen yearns for acceptance by his family, school and community and will eventually reach the ideal of "responsible adult," putting a job and family first in all statistical studies, even before the VCR, BMW and condo. It must be kept in mind that defects in lifestyle in adolescence may carry consequences long into adult life. Education and programs that reinforce social skills must be put in place. Experts and specialists who have dedicated years to the study of various aspects of human development spoke to a wide variety of professionals and volunteers from almost every state in the Union. Dr. Art Ulene gave a talk entitled "Television and Adolescent Health: A Help or a Hindrance?" It was a rational but controversial presentation that gave no hint of any change in network programming unless viewers show their disapproval of violence, etc. by simply *not* viewing the objectionable shows. Senator Paul Simon gave a scholarly view of the issues and talked about programs affecting health and welfare now being considered in Congress.

Problems of handicapped adolescents were discussed in one plenary session. This is a very compelling topic and one that is usually overlooked because of the all-encompassing physical and mental problems. It is a fact, however, that emotional, sexual and social development goes on for these young people and should be recognized and made easier for them.

There is no doubt that the high-risk teen from inner cities and rural areas faces the greatest danger from the stress of modern decay. A special plenary session was devoted to these underserved youth, and ways to "catch up," using private and public efforts, were outlined. Unfortunately, the number of poor has increased and their access to assistance has decreased. All panelists agreed that programs that help mothers and children such as WIC and Head Start, etc. are invaluable so that a healthy adolescence can be reached. They stressed, however, that a focus must be given to programs pertaining to teens who fall in the segment of our society that is less protected and more prone to fall prey to suicide, teen pregnancy, substance abuse, sexually transmitted diseases and violence.

Many awards were presented to individuals and agencies from all over the United States. Poster presentations of these programs made their work easily understandable. Dr. James Bazzoli (who spoke at Leadership Day at the OSMA Auxiliary meeting in Dayton) received an award for his Marion Adolescent Pregnancy Program in Marion, Ohio.

It is interesting that we already have implemented programs in some counties that focus on adolescent health, however I feel that a comprehensive approach would be most helpful. Perhaps the Auxiliary could sponsor community seminars on adolescent health with youth coalitions in view. Proctor & Gamble has instituted such a youth coalition in Cincinnati. It is my goal to visit this program to get more information. — *Doris Albernaz, Health Projects Chairman of the OSMA Auxiliary.*

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Socialized Medicine — The Patient-Victim

By Gerald Sutherland, MD

Editor's note: The following article has been reprinted with permission from ProMedica, the Toledo Hospital physician's journal. For more information, and other views on the Canadian health-care system, see the article "The Canadian Health-Care Paradigm" by Joseph C. Noreika, MD, immediately following this article, and "The Canadian Health-Care System: Is It Losing Its Appeal?" by former AMA and OSMA President John H. Budd, MD, elsewhere in this issue.

Several months ago an article written in a local newspaper suggested that Canada's health insurance is a model of universality.

The article implied, as do some of our country's influential politicians, that our system of medical care is outdated, and it has been recommended by Howard Hiatt, MD, that "the United States should give Canada's system a trial." Dr. Hiatt and our politicians, for political expediency, are quick to support a system of medical health care to meet immediate specific needs without regard for the long-range effects those proposals will have on patients and physicians.

In 1987, amid financial crisis and tumbling equity markets, our government reconfirmed and reinforced the Medicare system with catastrophic insurance. It thereby extended to the elderly under Medicare the benefits already offered to the indigent under Medicaid. However, the cost to the taxpayers, from whom the means to fund this program are to be extracted, is staggering. Current projections estimate that Medicare alone will cost $332 billion by the year 2,000 and that Medicaid will cost another $100 billion dollars. These cost estimates do not include the cost of treating those afflicted by the acquired immune deficiency

syndrome, which is likely to raise Medicare and Medicaid costs substantially.

Socialized medicine places politicians in charge of the health-care industry and delivers the system to an army of administrators and regulators. It follows that these same bureaucrats will obstruct and discourage health-care professions and ultimately will increase the cost and lower the standard of medical care, making the patient the ultimate victim.

Dr. Hiatt's recommendation of a trial of the Canadian system will divide society into two classes — the beneficiaries and the victims. The beneficiaries would be the politicians, officals and administrators who will battle for health-care funds while the patients and taxpayers suffer.

It has been reported that the Canadian medical standards are internationally recognized. Canadian propagandists are stretching the truth when they insist socialized medicine produces a bountiful distribution of all the medical care one could want or need. In reality, medical care is rationed. The denial of care to save money as a result of government intervention is evident in Ontario. A front-page article in *The Toronto Star* describes the plight of an arthritic patient, one of hundreds, who received a letter from the Toronto Orthopaedic and Arthritic Hospital, stating that his hip replacement surgery had been delayed for two years or more because of budget cutbacks demanded by the government. This internationally famous hospital, staffed by outstanding surgeons, has been ordered to perform only 300 hip and knee replacements during 1988 compared to its usual 500.

Because Canadian government costs are escalating, cuts have been made in hospital equipment, beds, staff and research. Ontario, in an attempt to save money, will eliminate 300 medical residencies in teaching hospitals over the next five years. This will effectively reduce access to medical care in the future. When faced with the huge costs of modern technology, Great Britain has denied kidney transplants and dialysis to patients more than 55 years of age, and some senior citizens cannot receive coverage for open-heart surgery.

Under a system of socialized medicine, hospitals must draw a distinction between urgent and nonurgent care. My mother, a recipient of Ontario's benevolent medical care, was required to remain in a noisy emergency bed for three days while waiting for a room in a Peterborough hospital. Hospital admissions and operations are cancelled at the last minute because beds, rooms and nurses are not available. This is not an isolated occurrence. Sick and injured people often wait for days in hospital corridors until space can be found for them. The cost of pain and patient lives is difficult to imagine.

In addition, the suffering patients may have to endure may be exaggerated by labor union activity to achieve political and economic advantages for its members. Labor unions are the first to recognize that monopolistic industries concede much more than those same industries under a competitive system. Union leaders are fully aware that a nationalized health-care system, created to provide medical services for all, cannot afford to shutdown. This has been shown to be true in Great Britain, where nurses have organized, and other militant unions in maintenance shops, ward clerks and security departments have confronted the system and gone out on strike, to the detriment of patient care.

The vast majority of doctors in this country are dedicated to the principle that every patient should receive the best of possible medical care, and that this care should be provided as long as it is needed regardless of the patient's financial condition.

The medical profession has long maintained that the government should provide for the poor so that no citizen should be denied medical care. However, before turning to socialized medicine, other options are available. At the very least, to encourage the private sector, insurance premiums, all medical bills, and medical IRAs or health-care savings accounts to meet chronic and catastrophic needs could be made tax deductible. Establishment of a voucher system for private health insurance with a variable amount of the annual voucher dependent upon the regional health-care cost differences and the beneficiary's income is a viable alternative.

The heresy of universality states that every citizen has the right to medical care but Congress mandates that a specific section of our society, the medical profession, now provide that service at a price the government is willing to pay. Thus, the universal is achieved through regimentation of a subsector of society. When society chooses to regard any profession in economic terms, the degradation of that profession inevitably follows. Rejection of a socialized medical system, which has already failed in Great Britain, Australia and New Zealand, and has had a detrimental effect upon the quality of health care provided to Canadian citizens, will allow the medical profession to operate most efficiently. Patients will remain free to choose their doctors, and physicians will have the freedom to determine the appropriate treatment for their patients. **OSMA**

Gerald Sutherland, MD, is an orthopedic surgeon from Toledo.

The Canadian Health-Care Paradigm

By Joseph C. Noreika, MD, MBA

This past presidential election campaign being no exception, the cost of America's health-care system once again became an issue. All Americans know that health-care costs are too high, that other worthwhile programs go begging at the health-care profession's expense, that this country cannot afford its current system of health-care provision. All Americans, that is, except those who would die without it.

I am a physician. I have a vested interest in the current supplier-driven system of health-care delivery. I make my living from it. I am also concerned about the cost of health care. I haven't been out of medical school long enough to wax nostalgic about the "golden years" of medicine in the middle of this century as some of my older brethren. I'm not young enough to be one of the brightest and the best to forego a medical career and get fulfillment from junk bonds and leveraged buyouts. My career goal remains the provision of excellent care to my patients.

A month ago, my wife almost died. My 36-year-old mother of four small children, PTA and Meals-on-Wheels bride of 12 years was almost a statistic. Born with a nerve conduction problem in her heart, she is one of some 20,000 people going about their daily business with this problem called Wolf-Parkinson-White Syndrome. A few weeks ago, she came close to being one of those very few young people who drop dead in perfectly good health. After the autopsy is completed, death is usually attributed to a cardiac arrhythmia, a deadly misfiring of the heart. While warming up to exercise, she felt her heart rate suddenly increase. Concerned that she might faint, she laid down and calmly took her pulse while watching the second hand of the wall clock, It was about 300 beats a minute, an excess of 200 or so. Afraid that dying might upset her exercise class, she got a ride home and then to a doctor. Her doctor got her pulse rate down after a few hours in the emergency room. Fortunately, she didn't have to wait for a bed.

Her problem required further study. A specialist in this particular heartbeat disorder happened to practice in Cleveland and, within a few days, a five-hour heart catheterization was performed to answer the riddle of how best to treat this life-

"It can be difficult to find a doctor in Quebec at the end of any given billing quarter."

threatening disease. Surgery was deemed the only curative option. And that brought us to Canada.

My wife's chest would be opened, and one (of 20,000) nerve pathway in her heart would be destroyed by freezing it. As a surgeon, my first question was, "What are the risks?" My second question was, "Which surgeon has done the most of these operations?" The risks were small and pertained more to the morbidity, the side effects of the operation, than to mortality, the possibility of dying. The surgeon who knew the operation best practiced his craft in London, Ontario.

In Ontario, every resident has had the right to free hospital care since 1959. Universal medical insurance began providing coverage for physicians' billings in 1969. Ontario and the rest of Canada took great pride in their wonderfully available health-care system. At least until they stopped to figure out what it was costing them.

In the mid-1970s the Canadian government mandated that accelerating health-care costs be controlled. Hospitals became targets. Strict budgeting requirements forced the reduction of treatment beds and the curtailment of services such as open-heart surgery programs. Attempts to close hospitals were made. This latter move caused such public outcry that the bureaucrats backed off. Managed with business-like accountability, Ontario's hospitals spent 2% of their allotted budgets for new equipment, physical plants and technology in 1982. Because of budget increases that lagged behind inflation, that surplus was eaten up by operating costs in 1988. Effects of this budgetary shortfall has resulted in the suspension of new program development, hospital infrastructure replacement, and technology acquisition and availability.

Ontario's 23,000 doctors have also experienced governmental cost-cutting. In 1988, physicians asked for a 5.7% increase in Medicare fees. A mediator has suggested an increase of 3.4% with a liability insurance premium adjustment. The government threatens to impose a unilateral 1.75% increase. In 1986, a 25-day strike by Ontario's doctors resulted from a similar impasse.

My wife received excellent, timely care. The delicate operation was a success. After five hours of heart surgery, she was back in her private room in less than 24 hours and discharged on the fifth post-operative day. This is certainly quick by American standards, but she is young and otherwise healthy. The key word is timely. We were from the States. We brought with us excellent private insurance and were afforded every consideration. Admitted to the hospital a day before it was necessary in order to guarantee her a bed, my wife was scheduled for surgery within two days of our arrival. I wonder about the Canadian whose place she took in the operating room that day.

You see, Canada's universal health insurance guarantees free hospitalization and doctor's care to everyone. The only drawback is that you must wait for it. Heart attack victims who require bypass surgery can wait six months before admission to the hospital where they might wait another two weeks before their surgery can be scheduled. A free artifical hip operation can be had in early 1990. Injured patients requiring physical therapy are put on waiting lists spanning six to 10 weeks. Even emergency patients can wait weeks before admission for surgery. Although denied by the government, physicians confided in me that patients were deteriorating and dying while waiting for definitive treatment.

Searching for novel means to reduce its health bill, the province of Quebec has imposed a limit on how much a doctor can bill the health insurance plan in any given year. This is called capitation. The physicians are paid quarterly. Once their limit is reached, they go on vacation. It can be difficult to find a doctor in Quebec at the end of any given billing quarter.

Why is this important? Presidential candidate Michael Dukakis advocated universal health insurance for this country. Under his administration, Massachusetts implemented a plan requiring employers to underwrite the insurance needs of their employees. An avowed admirer of the Canadian system, Dukakis used it as a paradigm for the Massachusetts plan.

It is politically difficult to oppose the provision of free health care to all citizens. Undoubtedly, it will be expensive. Unfortunately, costs will rise and rise sharply. Further cuts in reimbursement to hospitals, health-care programs and doctors will occur. Services will be reduced markedly. Availability and accessibility of care and new technology will diminish. And the American public will have to do something it hates to do. It will wait. Even if it kills them. **OSMA**

Joseph C. Noreika, MD, is a Medina ophthalmologist.

The Canadian Health-Care System: Is It Losing Its Appeal?

By John H. Budd, MD

As concern in this country increases over health-care costs, availability, distribution and quality there is a resurgence of interest in the Canadian system. It has been perceived by many, particularly politicians, economic commentators and reporters as efficient, thrifty, comprehensive and widely popular. A review of its history and development is timely.

It was started in 1967, established in all 10 provinces by 1971, and over its 20-year existence has received much scrutiny and critical analysis. There is no doubt that the plan has been enthusiastically adopted, endorsed and used by the public. Its principal appeal is the almost total exemption from any charge to the user at the point of service.

A high percentage of patients and a lesser percentage of physicians approved of the system. By 1978, however, after 10 years of experience, it became evident that all was not well. By 1988, some serious problems became obvious, and more recent polls now indicate a marked drop (from 80% to 60%) in Canadians' satisfaction with their health-care system.

Experience has shown that with all health-care systems, whether financed by governmental or private sector insurance, it is illogical and virtually impossible for any third party to be merely the insurer without exerting control over the services for which it pays. Acceptable quality and unlimited availability are confronted and restricted by cost.

We are repeatedly told by media, economists and politicians that between 11% and 12% of the national budget in the United States is devoted to health care while in Canada the figure is conspicuously lower. Overlooked by many is the fact that the Canadian government does not include any of the cost of its government buildings — or the maintenance of those buildings — in its health-care total.

Also overlooked is the point that Canada's health-care costs are divided between the federal government and the provinces. Initially the split was 50-50 but by 1977 the federal government reduced its share and it is now 38%.[1] The 62% provincial responsibility is heavy and largely met by taxation. In New Brunswick

there is a sales tax of 11%, in Nova Scotia 10%[2] and in Newfoundland, the last figures I have were 12%. Most provinces pay as much as 33% of their budget for health care.[3]

The efforts to reduce costs have included restricting services, cutting hospital budgets, limiting physician fees and curtailing ancillary services. Examples and consequences of these measures include:

1. Nurses quitting jobs, many of them moving to the United States. In the Feb. 13 issue of *Maclean's* magazine, a Canadian equivalent of *Time, Newsweek,* etc., it is stated that a $28,000 per year salary after 14 years of nursing experience is hard to accept when the U.S. offers up to $75,000 in salary, subsidized child care, free university tuition and less arduous schedules.[4]
2. Shortage of hospital beds. New Brunswick has closed 300 hospital beds in the past year. It is reported that 1,870 patients await surgery in Saskatoon University Hospital, Saskatchewan. In Toronto it is estimated that 1,000 people are facing waits of as long as a year for bypass operations at three hospitals. A report states that in January 1989 long waiting lists forced Toronto Sick Childrens' Hospital to send home 40 children who needed heart surgery.[1]

   At a medical conference in this country a Canadian orthopaedic surgeon told of a hospital in western Canada in which the total number of joint replacements permitted to be done by the surgeons of the orthopaedic department is limited to a maximum of six a month.[2]
3. To enforce acceptance of government-determined fees as payment in full, the federal government in 1984 passed the Canada Health Act. It was opposed by the provinces and by the Canadian Medical Association. It prohibited hospitals from imposing hospital usage charges to supplement Medicare payments and removed from physicians the privilege of billing any amount beyond the Medicare fee schedule. Any province that permitted its physicians to "extra bill" would lose federal grants.[3]
4. In an effort to limit the number and redistribute the supply of physicians in British Columbia, the Social Credit Government in power in that province in 1980 produced an order-in-council, which would deny licensure to new British Columbia medical graduates or physicians moving to British Columbia unless they agreed to settle in areas determined by the government to be underserved. It was challenged by the Civil Rights Commission, found to be discriminatory and was dropped.[5]

   The Canadian government uses statistics to its advantage, however, in calculating the number of physicians in practice. In Ontario, for example, there appeared to be "too many physicians," because the Ontario government was including residents in its count.

   And, in 1984, the British Columbia government, believing there were too many physicians in its province, denied a billing number to new medical school graduates (the equivalent of licensure). This was eventually overturned in court but for three years no new graduate of a medical school was allowed to practice in the province.[6]
5. As fees have been reduced, doctors are being accused of increasing patient visits, providing unnecessary services, doing too many tests and performing too many operations. To monitor physicians' activity in these areas the doctors are swamped by government laws, forms, restrictions and regulations. Responsibility and accountability must satisfy that most severe third party, the government. Doctor unhappiness has been increasing over the years. In 1982 general practitioners in Quebec went on rotating walkouts and during a five-day period treated only emergencies. They were legislated back to work. Failure to return to work would result in a fine of $200-$500 per day and a threat of a month in jail. This directive applied even to doctors who had, within the three-month interval, moved elsewhere. They could be fined even though they were permanently practicing in other provinces, or indeed, in another country.[7]

Ontario doctors at one time invoked a week of rotating walkouts and a two-day general strike, seeking salary increases. Newfoundland interns and residents went on a two-week strike to gain salary increases. The 1984 banning of extra billing provoked another strike by Ontario doctors. Rotating strikes have been carried out by Saskatchewan doctors. Medical interns and residents brought a lawsuit against the British Columbia restriction on licensure to underserved areas.[3]

Many doctors are leaving Canada and coming to the United States, including new and recent graduates as well as highly trained specialists of academic quality. In 1980 at the University of Ottawa Medical School, 63% of the third-year class had already taken U.S. licensing exams. At the University

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OBITUARIES

STEWART I. ADAM, SR., MD, Dayton; Jefferson Medical College of Thomas Jefferson University, Philadelphia, PA, 1943; age 70; died May 17, 1989; member OSMA and AMA.

CHARLES M. BARRETT, MD, Cincinnati; University of Cincinnati College of Medicine, 1939; age 76; died May 13, 1989; member OSMA and AMA.

CHARLES E. BOLINGER, MD, Marysville; Hahnemann Medical College of Philadelphia, Philadelphia, PA, 1940; age 75; died April 12, 1989; member OSMA.

PHILLIPS K. CHAMPION, MD, Dayton; Cornell University Medical College, New York, NY, 1933; age 80; died April 26, 1989; member OSMA and AMA.

GEORGE HASKEL CURTIS, MD, Pinehurst, NC; Washington University School of Medicine, St. Louis, MO, 1933; age 86; died May 11, 1989; member OSMA and AMA.

CARL F. GOLL, MD, Naples, FL; Ohio State University College of Medicine, 1938; age 79; died May 10, 1989; member OSMA and AMA.

DAVID L. GRALLER, MD, Cincinnati; University of Cincinnati College of Medicine, 1935; age 80; died May 21, 1989; member OSMA and AMA.

MILAN HALMOS, MD, Youngstown; Orvosi Fakultas Tudomanyegyetem, Budapest, Hungary, 1940; age 75; died June 1, 1989; member OSMA and AMA.

R. EMMET HANNON, MD, Lakewood; St. Louis University School of Medicine, St. Louis, MO, 1932; age 81; died April 7, 1989; member OSMA and AMA.

LOUIS A. LAME, MD, Stow; St. Louis University School of Medicine, St. Louis, MO, 1939; age 78; died May 25, 1989; member OSMA.

JOSEPH LEVEN, MD, North Canton; Ohio State University College of Medicine, 1932; age 81; died May 30, 1989; member OSMA and AMA.

EDWARD H. LO, MD, Warren; China Medical College, Taichung, Taiwan, 1970; age 45; died April 26, 1989, member OSMA and AMA.

CHARLES S. NOJONEN, MD, Ashtabula; University of Cincinnati College of Medicine, 1966; age 54; died May 15, 1989.

RALPH E. PICKETT, MD, Newark; Case Western Reserve University School of Medicine, 1933; age 81; died May 22, 1989; member OSMA and AMA.

ALOIS REBEC, MD, Barberton; Medicinski Fakultet Sveucilista u Zagrebu, Zagreb, Yugoslavia, 1946; age 76; died April 30, 1989; member OSMA and AMA.

OSCAR J. ROSEN, MD, Boca Raton, FL; Ohio State University College of Medicine, 1937; age 78; died March 27, 1989; member OSMA.

C.B. SCHOOLFIELD, MD, Upper Sandusky; University of Cincinnati College of Medicine, 1932; age 83; died April 14, 1989; member OSMA and AMA.

ROBERT B. WALKER, MD, Toledo; University of Colorado School of Medicine, Denver, CO, 1944; age 66; died May 13, 1989; member OSMA.

C.A. WATSON, JR., MD, Lakeside; Ohio State University College of Medicine, 1946; age 66; died March 30, 1989; member OSMA and AMA.

LAURENCE WEINBERGER, MD, Ojai, CA; Ohio State University College of Medicine, 1933; age 82; died May 27, 1989; member OSMA and AMA.

JAMES F. WHITACRE, MD, Toledo; Eclectic Medical College, Cincinnati, 1927; age 86; died May 25, 1989; member OSMA and AMA.

PAUL R. ZAUGG, MD, Naples, FL; Ohio State University College of Medicine, 1944; age 71; died April 18, 1989; member OSMA and AMA.

Editor's Note: *It has been called to our attention that* **OHIO Medicine** *inadvertently omitted the following obituaries. The* **Journal** *deeply regrets the error.*

ELSIE ASBURY, MD, Naples, FL; University of Cincinnati College of Medicine, 1920; age 92; died September 4, 1988; member OSMA and AMA.

JOHN R. BROWN, MD, Dayton; University of Cincinnati College of Medicine, 1945; age 66; died September 2, 1988; member OSMA and AMA.

RONALD FEGELMAN, MD, Cincinnati; University of Cincinnati College of Medicine, 1957; age 57; died August 2, 1988; member OSMA.

WILLIS T. KUBIAC, MD, Columbus; Ohio State University College of Medicine, 1939; age 74; died August 29, 1988; member OSMA and AMA.

ROBERT C. LEROUX, MD, Cincinnati; University of

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Ad Council

TWELVE IMPECCABLE EXCUSES FOR NOT GIVING BLOOD.

"1. I think I have lumbago.
2. I'm type Z negative.
3. I'm on the grapefruit diet.
4. I gave six months ago.
5. I just got back from Monaco.
6. The lines are thirteen blocks long.
7. My mother won't let me.
8. I didn't sign up.
9. I'm going out of town.
10. Asthma runs in my family.
11. I forgot to eat this morning.
12. I'm allergic to flowering magnolia."

Each one's a doozy, but we're hoping you won't use any of them. Give blood through the American Red Cross. Please, don't chicken out.

EXCUSES DON'T SAVE LIVES. BLOOD DOES.

American Red Cross

Third-Party Payor Calls — Nuisance or Necessity?

Here is what OSMA members have to say about this increasingly common practice . . .

Edited by Karen S. Edwards

Early this year, the OSMA's Task Force on Health Insurance Issues, chaired by Richard Villarreal, MD, Wheelersburg, surveyed the association's members to determine their opinion of certain third-party payor inpatient review activities.

The results of that survey, along with written comments made by OSMA members, are presented below. The OSMA will be working with the various carriers in the future to make suggestions, and help them improve their review programs.

The survey

Telephone requests for confidential patient medical information made to physicians and their office personnel from third-party payors, preadmission committee staff and various review organizations, especially related to currently hospitalized patients.

1. In your practice, do you receive inquiries such as the ones described above?
   - yes 81%
   - no 16%
   - don't know 3%
2. To your knowledge, do most of these calls originate from:
   - Ohio 27%
   - out-of-state 24%
   - don't know 34%
3. Do the majority of questions concern:
   - diagnosis 22%
   - treatment plan 23%
   - both 60%
   - other 6%
4. Who in your office most frequently answers these inquiries?
   - physicians 41%
   - nurse 21%
   - receptionist 20%
   - all 11%
   - other 5%
5. Do the calls usually involve quick, easy-to-answer questions, or are they more detailed?
   - easy to answer 33%
   - detailed information . . . 47%
6. How many calls do you

estimate your office handles per week?
- 1-5 ..... 52%
- 6-10 ..... 17%
- 11-15 ..... 5%
- 16-20 ..... 5%
- more 2%

7. Approximately how much time does it take on the average to handle these inquiries . . . time, research and follow-up?

	MD	Staff	Other
1-10 minutes	54%	32%	2%
10-15 minutes	9%	14%	1%
15-20 minutes	6%	9%	1%

8. Do you maintain written patient signature forms on file which permit release of this medical information to these agencies?
   - yes 29%
   - no 50%
9. Does the organization making the inquiry provide you with any information regarding the credentials of their personnel who make these calls?
   - always 7%
   - usually 16%
   - sometimes 13%
   - seldom 23%
   - never 23%
10. Do you verify the credentials of the individual who contacts your office for this medical information?
   - always 11%
   - usually 8%
   - sometimes 10%
   - seldom 20%
   - never 30%
11. Do you feel the individuals from these review agencies are usually qualified and adequately trained to discuss patient medical information?
   - always 1%
   - usually 18%
   - sometimes 33%
   - seldom 23%
   - never 5%
12. Do you think your patients know that their insurance companies may contact you for this medical information?
   - yes 24%
   - no 32%
   - don't know 24%
13. Do you inform your patients when their insurance company has called for this information?
   - always 13%
   - usually 18%
   - sometimes 25%
   - seldom 15%
   - never 9%
14. If you receive calls of this type from multiple agencies, have you noticed that they generally follow the same format in questioning, or does it vary group by group?
   - same general format ... 45%
   - varies by group 31%
15. Are you required by these review agencies to follow up in writing with more details after the telephone contact is completed?
   - always 2%
   - usually 5%
   - sometimes 20%
   - seldom 31%
   - never 22%
16. How often does length of stay change after interview by the reviewing agency?
   - 0% 30%
   - 1-5% 21%
   - 6-25% 11%
   - 26-50% 5%
   - 51-75% 6%
   - 76-100% 4%
17. What steps could be taken to make this process less time-consuming for you and your staff?
   - make phone contacts at time convenient to physician 28%
   - only contact affected physician by mail 28%
   - use standardized procedures 45%
   - other 17%
18. If telephone contact were to be limited, which of the following options would you prefer?
   - weekend only 1%
   - lunch hour 5%
   - late afternoon 13%
   - early afternoon 12%
   - after office closes each day 6%
   - early morning 16%
   - late morning 13%

Fifty percent of the physicians polled say they seldom or never verify the caller's credentials.

The comments

Survey respondents were invited to share their thoughts and suggestions on what the OSMA, and organized medicine as a whole, needs to do about the problems outlined in the survey.

Comments varied from the benign ("I don't find this 'problem' to be a problem") . . . to the resigned ("Nothing you can do. Live with it!") . . . to the hostile ("Toss the whole process into the trash can!").

Within this range of sentiment, however, were a number of points on which the respondents did seem to agree. For example:

Telephone calls unacceptable

Respondents had a number of problems with third-party reviewers who made their requests for further information by telephone. Many claimed they simply do not release information in this fashion.

"I am a member of a seven-physician OB/GYN corporation. Our office policy is that we do not discuss patient management,

current treatment or plans for release from the hospital with anybody over the telephone. All such inquiries are directed to write to us . . . we will answer any questions they have in a timely manner in writing."

Such telephone discussions make it difficult to retain patient confidentially, respondents continue.

"Breach of confidentiality is my main concern," writes one physician. "I generally have no documented proof of the patient's consent."

Another writes: "Telephone data is inappropriate because of the inability to verify the credentials of the caller."

A Toledo physician urges the OSMA to study this matter of confidentiality, asking: "Should we refuse to answer without the patient's permission? If so, will the patient's coverage be denied?"

Educating patients on what their insurance companies require may be one solution to this problem, respondents indicate.

"Patients are unaware if they need review on admissions or not. Education and documentation needs to be given to the patient so that they are are aware of what needs to be done, and also (so they) can provide the physician's office with adequate and accurate information," writes one physician.

Another points out that the OSMA needs to emphasize to patients that it is their responsibility to comply with any restrictions imposed by their insurance companies. "The physician does not (in most cases) have any contractual agreement with these plans."

And, adds another, "We don't have time to make sure the patient and the company's requirements are met — plus provide care!"

However, educating patients to gather the facts about their coverage and to authorize the release of information is still not going to make telephone calls from third parties any more acceptable to members. In addition to the sensitive matter of patient confidentiality, respondents provide two additional reasons:

1.) calls are an infringement on a physician's time.

2.) callers are rarely qualified to discuss medical matters with physicians.

Regarding the first matter, a Coldwater physician writes, "We spend 15 to 20 minutes handling or listening to recordings before we ever get a representative, because the lines are always busy. Then, we give the information to someone who always gives the information to a nurse (who then) calls back. Too much time is wasted (on repetition)."

And a Cincinnati physician writes, "First, my secretary tries to answer the questions, which she usually can't do, then I have to get on the phone. These are major interruptions. One call last week took 45 minutes of my time . . ."

The reason for these lengthy chunks of time frequently stem from the caller's credentials — or, more appropriately perhaps — the lack of them. Many of the physicians who answered the survey expressed frustration at having to justify their medical procedures to non-physician personnel.

"I find it offensive to have to (defend) my treatment plan to a nurse or other," writes a Delaware physician, while another respondent offers a specific example of how unknowledgeable callers can complicate matters:

"There does seem to be a lack of expertise on the part of these review agencies (with) regard to terminology. A patient of ours called her insurance company prior to being scheduled for a hysterectomy. She told the review agency that she was "having her uterus removed" and needed to know if preauthorization or second opinion was necessary. She was told no. Knowing that most companies require these procedures for hysterectomy, we suggested that she call the review agency back and be sure to specify 'hysterectomy,' not 'removal of uterus.' She was then told that, indeed, she would need preauthorization and second opinion."

Suggestions for improvement

Respondents were quick to make suggestions on how third parties could improve these matters:

"The OSMA should publish and regularly update the names and credentials of reviewers, so that there can be some assurance for the physician that he/she is talking with an appropriate person. Further, the OSMA should develop guidelines as to who are appropriate reviewers . . . ," one physician writes.

A Springfield physician adds, "Review personnel should be experts in the area they are reviewing. (They) need to be well-informed with ICD-9 and CPT coding." As an aside, this particular physician notes that, "on one occasion, this office had to make 12 different phone calls in an attempt to be connected with the right department for appropriate authorization for one admission."

Peer-to-peer telephone contact is not the only solution suggested by

respondents, however. A large number of them also indicated that phone calls and even written requests for information could be abolished if only third parties would seek their information from hospital utilization or quality assurance personnel.

"Insurance companies would get faster response and more action if they dealt with the local utilization or quality assurance nurse, who is usually better versed on requirements for hospitalization than the attending physician," writes a New Lebanon physician.

"OSMA needs to encourage insurance/third-party payors to initiate contact with hospital UR departments," agrees another respondent. "The information they need is normally available through a well-run UR program."

Others suggested that toll-free telephone lines be installed for physician use.

"Many carriers do not have these," one Marysville physician complains.

Another physician suggests that the responsibility of contact should fall on the insurance companies, not the physician.

"If it were the insurance company's responsibility to do all the contacting and reviewing rather than the physician's, it would alleviate the financial strain to physicians who, in thinking medically, do not remember to follow many variant insurance guidelines."

However, the most popular suggestion for improving the situation with third-party reviewers came in the form of a simple command: Charge the companies for the time spent in conference with them.

Some physicians, in fact, indicate that they already do this.

"Other physicians should do as I do. Unless I have a contract, such as with an HMO, IPA or PPO, I politely tell these people I charge $100 for any part of the first hour to talk with them — and I will need the name and address of whom to bill before we begin," writes one enterprising physician. "Then, they decide they don't wish to talk to me after all . . ."

A Boardman physician writes, perhaps tongue-in-cheek: "We need a CPT code to charge per minute for talking to these people."

While frustrations in dealing with third-party reviewers seem to elicit this kind of reactionary response, other suggestions submitted by survey respondents indicate that physicians have more than personal annoyances on their mind when it comes to the review process.

To discourage such calls, one physician writes, "I tell these people I charge $100 for any part of the first hour I talk with them."

"Insurance companies that deny admission or allow the patient fewer days as an inpatient should be held accountable for their action if a problem develops, as they — not the attending physician — are deciding how that patient should be treated," writes a respondent.

A Columbus osteopath carries that thought a bit further.

"The agency assigning length of stay should be required to carry malpractice coverage of at least a million (dollars) per occurrence, and to provide the affected physician with a notarized copy of the same — with expiration date marked and a clause to hold physician harmless — should poor outcome result from an early discharge."

In fact, a number of physicians responding to the survey believe that patients should be made aware of the fact that their insurance companies frequently involve themselves in the health-care decision-making process.

"(The OSMA should) do more public relations to help make the consumer aware of the interference certain types of health plans subject the treatment process to," writes one physician.

Another respondent takes another tack: "A public relations campaign (should be) directed toward the public's right for confidentiality," and yet another writes, "Inform patients that insurance companies will have a large say on how, when, where and how long they will be treated. The doctor and patient will have less to say (on this subject)."

And, since third parties are assuming more and more medical responsibility, perhaps the following suggestion, made by a Toledo physician, is not entirely out-of-hand.

"Review the review agencies. Call them with standardized problems and see if they have the training and expertise to answer. The companies that employ these agencies might be interested to have an independent party judge their competence."

The fault . . . lies in ourselves?

While the majority of comments sent in by respondents were typically critical of the third-party review process, there *were* physicians whose comments seemed to indicate that, while they may not be in favor of third-party review, they are, at least, tolerant

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Medicine's Brave New World: A Public Alert

Editor's note: *Robert J. White, MD, PhD, a Cleveland neurosurgeon and frequent contributor to* **OHIO Medicine,** *has already done what some answering this survey suggest — "notify the public about increasing third-party power." The following article appeared on the op-ed pages of a recent issue of the* **Cleveland Plain Dealer.** *We publish it here, with the paper's permission.*

Like so many of us, you have undoubtedly been under the impression that your physician is responsible for your medical care. Don't believe it. Your friendly health insurance company has now assumed your doctor's traditional role and, in the process, perniciously altered the delivery of medical care in this country.

These third-party insurance carriers have gained control of American medicine through the simple mechanism that they "pay for it," and, since they are businesses, they are primarily concerned about the cost rather than the quality of medicine. This has led to frequent inconveniences for the doctor and the patient. In addition, with this new emphasis on cost control, the doctor and patient are being placed in decision-making circumstances that are inappropriate and may be life-threatening too.

Let me give an example: I practice neurosurgery and, as a consequence, many of our operative procedures must be based on complicated and often invasive diagnostic procedures. Two of the most common of these procedures are myelography and cerebral arteriography.

Myelography involves the introduction of a radiopaque fluid into the liquid that surrounds the spinal cord, allowing the surgeon to see such abnormalities of the spine as disc compressions of nerve roots. Cerebral arteriography, which is essential for the study of vascular disease of the brain in such conditions as strokes and tumors, requires the injection of a special contrast solution into the arteries of the body so the blood vessels of the brain can be visualized.

In the past, we have considered such investigations as important, complex and mildly dangerous. As a consequence, patients were frequently admitted to the hospital the night before such studies and held in the hospital for a day or two afterward, whether surgery was undertaken or not. Thus, patients were in a hospital setting where they could be monitored and their safety and comfort maximized.

Nowadays, many insurance companies require the physician to obtain permission from them to carry out myelography or cerebral arteriography and that the patient come to the hospital on the day of the study and return home the same day, unless there are complications.

To make matters worse, they often insist that the surgery, be it spinal or intracranial, be performed the next day. Unfortunately your doctor may not be able to schedule the operation until it has been approved by the insurance company.

What the American public does not realize is that the insurance policy that covers their medical care has an established hospital length of stay for their particular disease or operation. It is the insurance companies that now dictate to the hospital.

Even the realities of having to make numerous visits to a hospital for laboratory and X-ray studies as an outpatient (rather than having them done at the time of admission), as well as the added discomfort of traveling to other doctors' offices for second or third opinions are all part of your medical insurance contract.

Patients who belong to the health maintenance organizations (HMOs) are really no better off, for they are invariably caught in a self-limiting "medical web." Under the provisions of their medical contract, they must see only a select group of physicians and be admitted to a single or limited number of hospitals, which are either controlled by or have financial arrangements with the HMO. If they should seek consultation or hospitalization outside of their HMO system, they will, in all probability, have to pay all the medical expenses.

Remember, the financial success of a health maintenance organization is based on reducing costs, which translates into giving as little care as possible.

Even patients whose health care is funded by the federal government, under such programs as Medicare and Medicaid, are no better off. The government is attempting to limit the financial outlay for these programs. So the elderly and the poor are in danger of having their health care compromised, for already the regulations that physicians must work under when treating these patients are often too stringent, demanding and, on occasion, dangerous.

For these reasons, and also the fact that physicians' fees have been frozen for a number of years, the pool of physicians willing to treat the elderly and the poor is shrinking.

The health insurance industry is rapidly gaining control of medical practice in this country. Tragically, the patient (the consumer) and physician (supplier) are rapidly becoming nothing but units in an economic system where cost is more important than quality. Welcome to the brave new world of medicine. — *Robert J. White, MD, PhD*

of the practice.

Writes one physician, "We need to educate the membership how to handle their calls. These reviews are a fact of life. The membership should be encouraged to do everything possible to protect that patient's interests."

Another of the survey's respondents urged the OSMA to "help educate physicians to be very professionally sound in their diagnostic and treatment approaches, and pleasant as much as possible . . . we do have to accept the reality of a rapidly changing and expanding health-care community."

"Stop being outraged by having someone raise a question of medical necessity and appropriateness," writes another — while still another wryly notes, "I feel (that the review process) is far less of a problem with insurance companies than it is with welfare, government, abuse agencies, etc. They can bug you to death!"

A solution to the entire intervention problem is far from clear. As one Oregon, Ohio physician writes:

"I have no idea what can be done to solve this problem. However, we're all drowning in a sea of forms and paperwork."

And, right now, no end to the paperwork is in sight — whether those forms are being generated by governmental agencies or from third-party payors.

Perhaps the best that can be done, then, is to follow the advice of one survey respondent, who, while addressing the problem with third parties specifically, may have had all other intervening agents in mind when commenting: "Cooperate, play the game, encourage providers to learn the system — and I believe the insurance companies will self-destruct with their own bureaucracy . . ." **OSMA**

AIM HIGH

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AIR FORCE

The 1989 Inaugural Address to the OSMA House of Delegates

Given May 7, 1989
By William J. Marshall, MD

Members of the House, Officers, Auxilians and distinguished guests:

This is a historic occasion tonight. Not only historic for me personally and for my family, but historic for the association as well. This is the first time in the Ohio State Medical Association's history that a husband and wife have served simultaneously as presidents of OSMA and the OSMA Auxiliary. I stand here honored, humbled and searching for equanimity.

To mark this special occasion, we have chosen a symbol, the triangle, the symbol of our collective organizations. Within the large triangle are many smaller triangles representing our collective membership. On one arm, the physicians of Ohio, on the opposite arm the Auxilians, meeting at the apex, forming a vector, the force of which will form the base of our triangle, which portends an equation for change. This symbol represents our common philosophy, which will be woven through the threads of our work in the next 12 months.

Clearly change is inevitable and challenging. We have been given by you the unique opportunity to combine the strength, talents, ingenuity and vitality of the OSMA and OSMA Auxiliary to ensure the changes occuring will enhance our work products — quality health care for the citizens of Ohio, our patients.

The question remains then, how will this philosophy be translated into action for our two groups? First and foremost, on all issues facing our two organizations, we will emphasize unity and teamwork.

Medicine is the only global profession in which everyone follows the same methods, is activated by the same goals and pursues the same ends. This homogeneity is not shared by any other profession. It is this solidarity of purpose that allows the rural, small city and metropolitan physician to gather together at meetings such as this to discuss and resolve issues common to the practice of medicine, no matter its location. We disdain the twilight, looking only for the dawn, as we search for answers to conflicting problems, such as new diseases, high technology and an unrelenting pressure to cost containment.

Unity promotes concord. Barbara and I plan to foster unity and concord between our two organizations. Our ultimate goals are to provide necessary services to our membership, enhance the meaning of belonging and to improve the quality of life for Ohio's citizens through health education, services and new programs.

The Auxiliary will continue its focus on adolescent health issues, with an emphasis on teen pregnancy, AIDS education, smokeless tobacco and the health consequences of excessive tanning.

As the momentum builds toward a smoke-free environment, we will ask physicians' offices to join in this movement by banning smoking in their common areas, such as the waiting room. In addition, we will ask each physician to actively counsel their patients on the health consequences of smoking during routine visits to see the doctor.

In Hippocrates' First Aphorism he described the public spirit of physicians — that is the responsibility of physicians to extend themselves beyond patient care to the community and society at large. One year ago, as I met

with each district caucus before the election, it was in the spirit of altruism that individuals asked what we as a professional society might do about the plight of the homeless and the uninsured. I knew then, if elected, recognizing the need to preserve the passion to help and care for those outside the system, these problems would find a place in our agenda.

First of all, let's address homelessness. It is estimated that there are 140,000 homeless people in Ohio, and that figure is projected to grow at a rate of 10% a year. This group of people have high prevalence of medical and mental health problems and frequently use public emergency departments. Our goal will be to understand the special health problems associated with homelessness and devise an overall strategy to provide health services to manage their specific health needs.

Regarding the uninsured, if this problem is not resolved, it will erode the very principles on which our health system has been built. There is a strong belief in this country that all citizens deserve a level of universal access. But cutbacks in Medicare and Medicaid, with private insurers following suit, are threatening this access. As a result, there has been a real and measurable deterioration of health care for an ever increasing number of Americans. In the state of Ohio this represents 1.4 million people, of whom 400,000 are children. Our plan is to press for legislative changes that will provide basic coverage for all those who are uninsured.

We must recognize that in today's health-care environment, there will continue to be limits in health care. The real question is: Who will decide what those limits are? I think *we* must decide and we must do it by forging a partnership between public policymakers at the state legislative level and leadership in the medical community. Such discussions have already been held in the state of Oregon and in Alameda County, California. A panel of physicians and others, guided by an ethicist, are working together to rank health-care services according to their benefit for the most people. The final decisions about health-care rationing must be left up to the politicians and the public to draw the line between services to be provided and those to be denied, based on funding.

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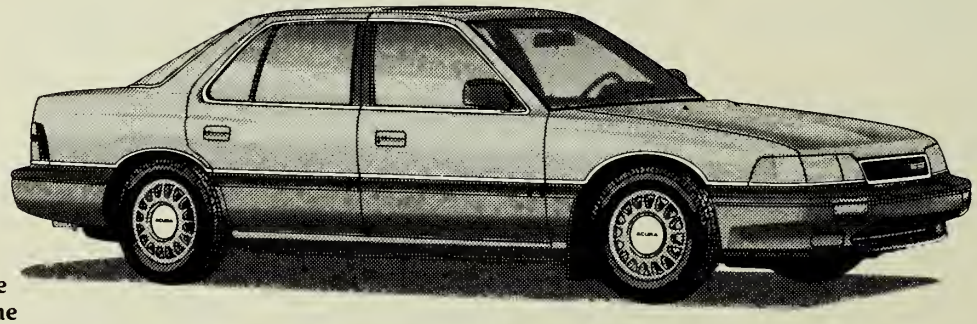

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I firmly believe that the political environment of medicine in the remainder of this century makes an organized and effective grass-roots lobbying program a necessity. The Auxiliary is to be congratulated for its Day at the Legislature — an excellent grass-roots program that has heightened awareness — but we will need more physicians and Auxilians to participate. We also need member volunteers to testify, become key contacts and work in political campaigns. It is imperative that every Ohio State Medical Association and Ohio State Medical Association Auxiliary member understand that it will be political decisions that determine the future of America's health-care delivery system. As a constituent, the relationship you forge with your legislator can help determine how those decisions will be made. We *can* make a difference.

During the past decade the environment of medicine has undergone considerable change. These changes have raised bioethical issues posed by medical technological advances and alterations in the medical industry relationships. The practice of medicine has some unique aspects wherein a potential ethical dilemma may exist. The decision to render a service is made by the individual who ultimately renders it. Society expects our profession to explore these issues — they are timely and we will accept the challenge I have asked William Kose, Chairman of OSMA's Judicial and Professional Committee, and he has accepted the challenge in behalf of his committee, to proactively explore and study the ethical issues facing our membership. My hope is that from this committee's deliberations will come guidelines for practicing physicians to follow.

Aggressive government and third-party payors are impacting on the delivery of health care in Ohio and in our nation. Their maneuvers have resulted in creating obstacles and limiting access, a form of health-care rationing. Their actions are discouraging to physicians as these phantoms continue to usurp the doctor's authority, yet expect the profession to carry all the responsibility. Accordingly, I have formed a new committee — the Committee on Relations with Third-Party Payors and Government, which will be chaired by Donavin Baumgartner, Jr., MD, immediate OSMA Past President. The committee's mission will be to meet individually with the above entities, improve communications, question proactively and hopefully improve the practicing physician's understanding of these changes.

There are many problems facing our health-care system today that our forefathers didn't even imagine. But by identifying these problems and by working together with the Auxiliary, we *can* make a difference in resolving the problems — whether the issue is homelessness or rationing. Physicians Plus Auxilians — we are truly an equation for change.

Finally, in the words of Emerson:

"Life is too short to waste,
In critic peep or cynic bark,
Quarrel or reprimand;
"Twill soon be done;
Up! Mind thine own aim, and
God speed the mark!" **OSMA**

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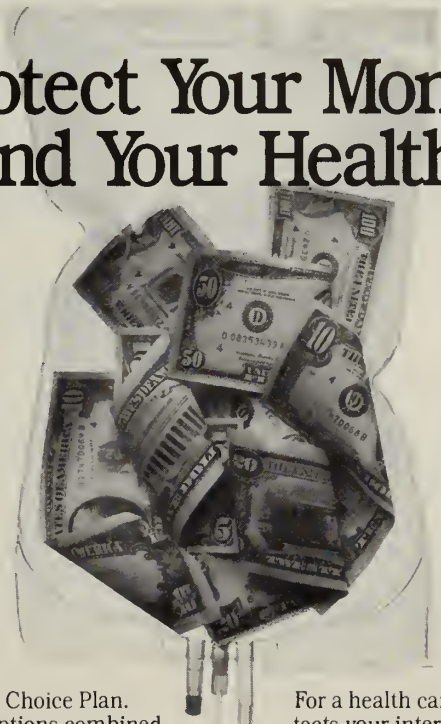

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A WORD TO THE WHYS

WHY AMA? The AMA has tackled the issue of cost effective quality medical care by supporting the development of health care coalitions. The Association believes the best mechanism for keeping health costs down without sacrificing quality or accessibility is through voluntary coalitions in which physicians actively participate. Working to promote high quality, affordable medical care in the United States: it's one more good reason why you should be a part of the AMA.

WHY AMA? The AMA has actively sought to attract women as members and leaders in organized medicine. Ongoing AMA projects and concentrated efforts by county, state, and specialty societies have significantly increased the leadership role and membership of women in organized medicine. Strengthening the voice of women in medicine through encouraging active participation: it's one more good reason why you should be a part of the AMA.

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AIDS: Not the Only Infectious Killer

By Michelle J. Carlson

When Edward Lo, MD, a Howland obstetrician/gynecologist returned home one evening in late 1987 feeling very tired, he dismissed it as fatigue. A glance in the mirror, however, revealed a yellow tinge to his eyes.

Tests performed a few weeks later confirmed Dr. Lo's suspicions: He had contracted hepatitis from one of his patients. The disease progressed to the point where Dr. Lo's liver failed, and in November he received a liver transplant. Though he seemed to be recovering, a few months later Dr. Lo died.

His untimely death not only shocked the Trumbull County physician community but prompted many of his colleagues to re-examine the precautions they take to prevent exposure to their patients' blood and body fluids.

"The thing that destroyed me (about Dr. Lo's death) was when he returned from his transplant he was looking so good," says Howard C. Adelman, MD, a friend and colleague of Dr. Lo's. Dr. Adelman, a Warren pathologist, says he believes Dr. Lo took precautions to protect himself from the patient's body fluids. "As far as I know, he was splashed in the eyes by amniotic fluid when delivering a baby," he says. "I think he took precautions. He wore glasses — his own eyeglasses — but (the amniotic fluid) sprayed behind them." (Incidentally, mother and child both succumbed to hepatitis.)

Vaccinations increasing

Dr. Lo, says Dr. Adelman, was vaccinated against the disease, but apparently it failed. "He had the vaccination. He went through the series, but he never got a titer to see if it took, at least not until he got infected," Dr. Adelman says.

After Dr. Lo was diagnosed,

concern among physicians for their own safety rose at area hospitals.

M.E. Sorrell, MD, director of medical affairs at Trumbull Memorial Hospital, said in January in a *Tribune Chronicle* article that "Dr. Lo's illness and surgery increased the awareness for the need for vaccinations among local doctors . . . Anyone who comes in contact with blood is at risk not only for hepatitis, but also AIDS. I know of at least 12 physicians who were vaccinated after hearing about Lo's experience."

"I've seen that health-care workers are going further to adhere to universal (precautions) . . ."
— Leonard Blass, MD

Dr. Adelman concurs, saying that at St. Joseph Riverside Hospital, where Dr. Lo was initially treated, physician concern increased sharply.

"We had a flood of people who came in to get their vaccination shots," he says, adding that "I certainly hope (their concern) lasts."

Leonard Blass, MD, Director of Infectious Diseases at Trumbull Memorial Hospital, also agrees that Dr. Lo's infection caused concern among physicians.

"I think the impact (of Dr. Lo's death) brought to the attention of physicians that hepatitis B is more common than they realize," Dr. Blass says. "It's especially a risk for physicians who do invasive procedures."

The incident, he adds, "was a catalyst in getting physicians to be vaccinated for hepatitis B. I think it's become mandatory, if not a law for dentists (to be vaccinated), but that's not the practice for physicians."

Dr. Blass believes that the fairly recent introduction of the new hepatitis B vaccine has also led to more health-care workers becoming vaccinated because they believe the synthetic vaccine is safer than the old, serum-derived vaccine (though Dr. Blass personally doesn't think the new vaccine is any safer).

Meanwhile, it appears that the number of cases of hepatitis is rising. According to the Ohio Department of Health, in 1988 in Ohio 557 cases of hepatitis were diagnosed. Says Carol Jacobson, RN, Infection Control Consultant for the department, "I do know cases of hepatitis exist because (people) aren't getting vaccinated," but she is unsure how many are physicians.

Dr. Blass, however, cites Centers for Disease Control statistics that show that "There are thousands of cases of occupationally acquired cases of hepatitis B infection every year . . . (so) it's not an isolated thing. It happens from time to time."

Taking precautions

It has long been recognized that the possibility of contracting a patient's disease or infection is an occupational hazard for physicians, particularly for those in such high-risk specialties as surgery, obstetrics and gynecology and emergency.

But how many of those physicians actually adhere to the CDC's recommended universal blood and body fluid guidelines?

At Trumbull Hospital, "What we teach is that these (precautionary) techniques should be applied to all patients, not just those who we know are infected," says Dr. Blass, adding that "I've seen that health-care workers are going further to adhere to universal (precautions) more than before . . . so I think the practices have changed over the past several years."

Jacobson, on the other hand, doubts that many physicians are strictly following the CDC's recommendations.

"(Physicians) have been told so they're all aware of (the guidelines) . . . but to be honest, the majority of doctors we deal with do not take universal precautions."

That probably wouldn't surprise Dr. Adelman, who thinks that more than a few physicians are lax about protecting themselves. "There's so much concern for AIDS," he says, that some physicians tend to forget that hepatitis B is easily transmitted, and take precautions only when they think a patient is infected with AIDS. That, Dr. Adelman says, can be a deadly mistake.

"You should regard every patient as being dangerous," he says. "Physicians can't afford to let their guard down."

In the Trumbull County Medical Society *Newsletter,* Dr. Adelman, who is the editorial manager, offered his colleagues the following guidelines:

"To be honest, the majority of doctors we deal with do not take universal precautions."
— Carol Jacobson

- Get the hepatitis B vaccine series and have your blood tested at the end of the series to

be sure you have developed antibodies.
- Practice universal blood and body fluid precautions. Wear protective eye shields and rubber gloves.
- Wash your hands — frequently and thoroughly. Your hands can never be too clean.

". . . A few of us suffer so much damage the liver ceases to function."
— Edward Lo, MD

- Don't ignore any injury or self-contamination, no matter how trivial it may seem.
- Clean and disinfect areas that have become contaminated by blood or other body fluids.
- Realize that AIDS and hepatitis can strike anyone. They are equal opportunity destroyers.

Shortly before he died, Dr. Lo told the *Tribune Chronicle,* "I'm speaking out because hepatitis B is very infectious. At Presbyterian Hospital (where he was treated) they told me there are 300,000 new cases each year in the United States. It is transmitted through body secretions, not social contact, and some types of hepatitis don't cause much problem. Most patients recover, but a few of us suffer so much damage the liver ceases to function."

Lo added that if anything good came from his misfortune, it was the renewal of his colleagues' awareness of the disease and how it is contracted. **OSMA**

Michelle J. Carlson is Editorial Assistant for **OHIO Medicine.**

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ANNUAL MEETINGS

A Glimpse at 1989

OHIO CHAPTER, AMERICAN COLLEGE OF SURGEONS
MAY 11-13, 1989

Immediate past president Richard Fratianne, MD, Cleveland, D. Ross Irons, MD, Bellevue, and Richard Reiling, MD, Dayton.

Dr. Fratianne addresses the meeting.

(Right) John B. McCoy, MD, Immediate past president, Elyria.

(Below) John B. McCoy, MD, (r.) presents Silver Medal Award to Charles Miller, MD (l.), Akron.

Silver Medal Award winner N. Ray Baumgartner, MD, Cincinnati.

OHIO STATE RADIOLOGICAL SOCIETY
MAY 27-30, 1989

IN PROGRESS:

Specialty Societies

OHIO OPHTHALMOLOGICAL SOCIETY
June 2-4, 1989

William Reinhart, MD, Cleveland, attends the meeting.

Robert T. McKinlay, MD, Westerville President, OOS. presents an award to Marilyn Huheey, MD, Columbus, in recognition of her service to the OOS Board of Directors.

Physicians exchange views during the meeting.

Lawrence Singerman, MD, President-Elect, OOS; George Garcia, MD, President-Elect, American Academy of Ophthalmology; Robert T. McKinlay, MD, Westerville, President OOS; Froncie Gutman, MD, Cleveland, Member, Board of Directors, AAO.

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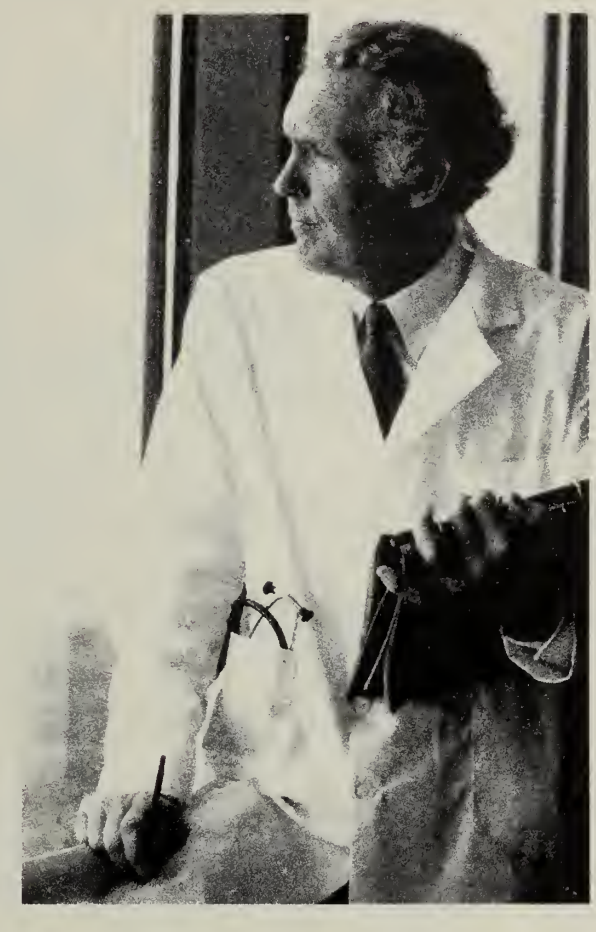

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Results of the Resident Survey

By Louis A. Cannon, MD
President, OSMA-RPS
Cardiology, University Hospital
Cincinnati, Ohio

The OSMA-RPS has been active in its first official year of activity. A statewide resident survey was completed and tabulated, prompted by concern over legislation potentially affecting the hours and the quality of care residents provide. An outstanding 30%+ of Ohio's 3,000 residents responded with responses from all of Ohio's training programs and specialties. The questionnaire surveyed residents regarding their work hours and inquired as to potential strategies to correct scheduling problems without affecting the quality of care we provide. The results were interesting:

- 71% of residents felt that resident work hours need to be regulated
- 57% thought the RRCs would need to take control to effect the regulation
- 20% thought hospitals should regulate the hours
- 15% thought the government should intervene
- 60% thought that work hour limitation would improve the quality of care residents provide
- 79% of residents were on call two or three times a week making the average work week in excess of 100 hours a week
- 40% did not have at least one day off per week

The majority of residents felt that regulation of work hours would ultimately lead to less tired, more efficient residents who are more interested in the care they deliver, however, this feeling was not unanimous. Other residents felt that ". . . doctors aren't hourly laborers . . ." and that regulation might ". . . change medicine into a nine-to-five occupation." Several residents commented that their efficiency decreases with a 36-hour workday, and the majority implore medicine to regulate the problem before the government does it for us.

In addition to the Ohio resident's survey, we organized district meetings held in six of Ohio's major teaching areas to identify local problems. Although the attendance was disappointingly low, with no one attending at Toledo, the district meetings were productive in terms of stimulating discussion regarding local concerns to be addressed at state and national levels. A short list of these include: a concern over mandatory helicopter flights for emergency medical residents in training, problems concerning appropriate hospital security procedures, and the dilemma concerning the adequacy of malpractice insurance and tail coverage for residents in an era of litigation, claims-made policies, self-insurance, hospital closings and mergers.

The next few years will show increasing amounts of visibility from Ohio's residents as we become active in task forces regarding the homeless, political action committees, RRCs and the OSMA. Our state meeting will be held in the fall of 1989. The stage is now set to make the 1990s a time to address the concerns of Ohio's next generation of physicians, and to have an active say in the laws and industry that affect the care we provide. **OSMA**

Current Management of Chronic Congestive Heart Failure

By Richard P. Lewis, MD

Recent studies have shown that an excessive neurohumoral response to the failing heart may be as important as the type of underlying heart disease in determining the clinical course of chronic congestive heart failure (CHF). The neurohumoral response, which was evolved to protect against hypovolemia, consists mainly of the sympathetic nervous system and renin-angiotensin-aldosterone system and is regulated by baroreceptors distributed throughout the circulation. Because the response does not correct the low cardiac output, "overshoot" develops as a consequence of blunted baroreceptor sensitivity. The result is excessive vasoconstriction and fluid retention which produces increases in ventricular preload and afterload.

Myocardial hypertrophy is the primary cardiac response to the variety of disorders which cause chronic CHF. Indeed, myocardial mass is usually at least twice as normal in CHF patients. The hypertrophied ventricle has diminished diastolic distensibility and coronary perfusion is impaired. Atrial hypertrophy is required to produce adequate ventricular filling during atrial systole (manifest by an S4 gallop).

Eventually inappropriate ventricular dilatation (fiber layer slippage) develops as a result of chronic excessive preload and afterload. Chronic subendocardial ischemia also plays a role in this process. Tachycardia, which is usually present, aggravates subendocardial ischemia by reducing coronary perfusion time (which is virtually entirely diastolic) and increasing oxygen demand. Subendocardial ischemia produces contractile dysfunction ("hibernating myocardium") and eventually cell death. This can occur in the absence of obstructive coronary artery disease.

The decompensation phase is signaled by a drop in the left ventricular ejection fraction. Left atrial failure often occurs concurrently and is manifest by a rise in mean atrial pressure and the appearance of an S3 gallop. The decompensation phase may develop rapidly following acute myocardial injury or may develop only after many years of successful compensation as in valvular disease or hypertension. Once it develops, a vicious cycle begins which generally results in death within one to two years.

The most successful strategy for managing congestive heart failure would be to prevent the

decompensation phase. Indeed, this can be accomplished by valvular surgery or successful anti-hypertensive therapy. However, in most cases of myocardial disease (cardiomyopathy or ischemic heart disease) the goal of therapy is largely to postpone or mitigate decompensation.

To this end, three major classes of agents have been shown to be effective and their effects are additive: diuretics, digitalis and vasodilators (the so called "triple therapy"). In addition, periodic dobutamine infusions and beta adrenergic blocking agents may benefit selected patients. Salient features of each mode of therapy are summarized in the subsequent paragraphs.

Diuretics — Thiazide and loop diuretics are complementary and many patients require *both.* Failure of modern diuretic therapy is usually due to inadequate sodium restriction. Hypokalemia must be assiduously avoided as it is a major contributor to lethal arrhythmias (40% of CHF patients die suddenly). Overdiuresis occurs in up to 10% of patients and mimics worsening heart failure.

Digitalis — Recent randomized placebo controlled trials have clearly established efficacy in patients with sinus rhythm. Obviously, digitalis is indicated when atrial fibrillation is present. Unlike diuretics or vasodilators, digitalis increases the ejection fraction, as well as improving abnormal hemodynamics. Myocardial energy metabolism is favorably affected by slowing the heart rate. Atrial muscle failure may be reversed. Digitalis also restores baroreceptor sensitivity and thereby inhibits the neurohumoral response. Diuresis is enhanced by increased renal blood flow and direct inhibition of sodium reabsorption. There has been no evidence for a

proarrhythmic effect in short term trials. However, the effect on long-term mortality has not been studied. An S3 gallop is a useful clinical marker for a population highly responsive to digitalis. Toxicity is minimal (less than 5%) if serum level is maintained in the therapeutic range. Digitalis is the only approved oral inotrope. Newer alternative oral inotropes have thus far been disappointing for chronic therapy.

Dobutamine — Periodic three-day infusions (while monitored in the hospital) produce dramatic hemodynamic improvement in many patients which may last for weeks or months. The mechanism of sustained improvement is probably due to reversal of subendocardial ischemia.

Vasodilators — Converting enzyme inhibitors are the premier agents. They reduce both preload and afterload and inhibit the neurohumoral response. Signs and symptoms are improved but this often requires several weeks. A recent study showed that excessive cardiac dilatation after large anterior infarction can be minimized (thus delaying the decompensation phase). Another study showed that one-year mortality of Class IV patients is substantially reduced largely by preventing progressive myocardial failure. Since converting enzyme inhibitors are the only agents that prolong life in chronic CHF, it can be argued that they should be instituted as early as possible. Side effects (mostly hypotension) are not uncommon and unfortunately the cost is up to 10 times greater than for digitalis or diuretics. Nitrates can be added for patients with severe ventricular diastolic dysfunction. Hydralazine-isordil combination may be used when converting enzyme inhibitors are not tolerated since this combination has also been shown to improve mortality.

Beta Adrenergic Blocking Agents — There is limited clinical experience but remarkable improvement has been reported in selected patients. The mechanism of beneficial effect is probably related to slowing the heart rate, but up-regulation of myocardial beta adrenergic receptors may also play a role. A large clinical trial is in progress.

References

1. Packer M. Therapeutic options in the management of chronic heart failure. Is there a drug of first choice? *Circulation* 1989; 79:198.
2. Packer M. Vasodilator and inotropic drugs for the treatment of chronic heart failure: Distinguishing hype from hope. *JACC* 1988; 12:1299.
3. DiBianco R, Shabetai R, Kostuk W, et al. A comparison of oral milrinone, digoxin, and their combination in the treatment of patients with chronic heart failure. *NEJM* 1989; 320:677.
4. Parmley WW. Pathophysiology and current therapy of congestive heart failure. *JACC* 1989; 13:771.
5. Katz AM. Changing strategies in the management of heart failure. *JACC* 1989; 13:513.
6. Lewis RP. Digitalis In Cardiotonic Drugs: A Clinical Survey. CV Leier ed. Marcel Dekker Inc., New York, 1987, pp 85-150.

7. Fisch, C., ed. William Withering: An account of the foxglove and some of its medical uses 1785-1985. *J Amer Col Cardiol* 1985; 5A:1-123.
8. Lee DC, Johnson RA, Bingham JB, Leahy M, et al. Heart failure in outpatients: A randomized trial of digoxin versus placebo. *New Eng J Med* 1982; 306:699-705.
9. Gheorghiade M, St. Clair J, St. Clair C, Beller GA. Hemodynamic effects of intravenous digoxin in patients with severe heart failure initially treated with diuretics and vasodilators. *J Amer Col Cardiol* 1987; 9:849-857.
10. The Captopril-Digoxin Multicenter Research Group. Comparative effects of therapy with captopril and digoxin in patients with mild to moderate heart failure. *J Amer Med Assoc* 1988; 259:539-544.
11. Guyatt GH, Sullivan MJJ, Fallen EL, Tihal H, et al. A controlled trial of digoxin in congestive heart failure. *Am J Cardiol* 1988; 61:371-375.
12. Unverferth DV, Magorien RD, Lewis RP and Leier CV. The role of subendocardial ischemia in perpetuating myocardial failure in patients with nonischemic congestive cardiomyopathy. *Am Heart J* 1983; 105:176-179.
13. Yusef S, Wittes J, Bailey K, and Furberg C. Digitalis — A new controversy regarding an old drug. The pitfalls of inappropriate methods. *Circulation* 1986; 73:14-18.
14. Smith TA. Should digoxin be the drug of first choice after diuretics in chronic congestive heart failure? Protagonists viewpoint. *J Am Col Cardiol* 1988; 12:267-271.
15. Pfeffer MD, Lamas GA, Vaughan DE et al. Effect of captopril on progressive ventricular dilatation after anterior myocardial infarction. *NEJM* 1988; 319:80.

Richard P. Lewis, MD is a Columbus cardiologist.

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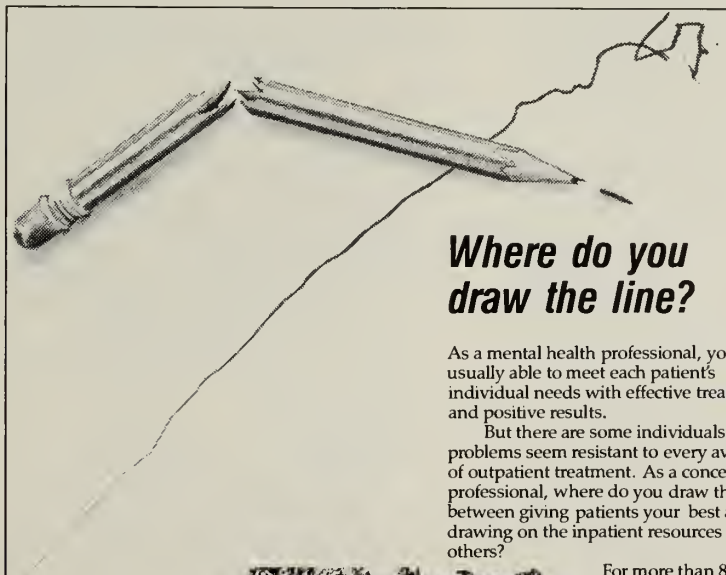

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of Toronto, 46% said they had already taken the tests, and 39% of the remainder said they intended to soon.

Doctors leaving Ontario to practice in the U.S. numbered 282 in 1974, 549 in 1977 and 531 in the first nine months of 1978. This number, 531, is the approximate equivalent of the total graduating classes of the three Ontario schools of that year.[10]

Like the British, Canadian physicians by instinct, tradition and culture have always been law-abiding, cooperative and non-militant in self-seeking goals. I believe that in the development of government-financed health care they expected the same qualities in politicians, and they were considerably deceived. Their frustrations and dissatisfactions have indeed been severe. They have been coping as best they can, and they still provide superb care despite their disappointments.

Robert G. Evans, of the University of British Columbia, one of Canada's best known health economists, in an interview was quoted on Canada's national health insurance plan as follows: "There is a basic conflict in a policy that says government must control its budget, health-care funding must be universally available, physicians must retain their professional autonomy, and consumers must have free choice of providers. There is no obvious mechanism for resolving this conflict, and no politician wants to tear down the system that is in place. This dilemma, I might add, is not unique to Canada. In one way or another, it is prevalent throughout the Western world."[3]

While there is little risk or likelihood that Canada's Medicare will be terminated, it is increasingly clear that fundamental changes must occur for it to survive. The biggest threat to solvency is the cherished principle of unlimited access for every citizen, to every medical service, equipment and facility free of charge. Withdrawal or limitation of this benefit would be almost politically impossible, but a feasible alternative is difficult to imagine. A suggestion from Fraser Detwiller in 1980 called for some sort of compromise between government-sponsored programs and the present voluntary program, which might adopt the advantage of both and the disadvantage of neither.[5]

It is essential that the medical profession be alert, informed and effectively represented in all discussions and legislative proposals on this problem. **OSMA**

John H. Budd, MD, Cleveland, is a Past President of the OSMA and AMA.

References

1. J. Barber. Sick to Death. *Maclean's.* Feb. 13, 1989.
2. Personal experience.
3. John Iglehart. Canada's Health-Care System. *N. Engl. J. Med,* Jul 17, 1986.
4. Barbara Wickens et al. Looking for a Greater Voice. *Maclean's,* Feb. 13, 1989.
5. Lloyd Detwiller. Point of View: Health Plans at the Crossroads. *HCM Review,* Winter 1980.
6. J. O'Brien Bell, MD; Leo-Paul Landry, MD; Hugh Scully, MD, *AMNews,* March 10, 1989.
7. Special Bulletin. Canadian Medical Association. Re: Quebec Medicare and Medical Services Withdrawal, October 19, 1970.
8. MDs at the Crossroads: Union vs. Society Representation. I.G. Yablon, MD, *Massachusetts Physician,* April 1975.
9. Ken Whittingham. Notes from Canada. *The Chronicle of Higher Education,* April 28, 1980.
10. Henry Giniger. Doctors' Rebellion Imperils Canadian Health Plan. *NY Times,* March 18, 1979.

Cincinnati College of Medicine, 1966; age 49; died August 1, 1988; member OSMA.

REGIS J. MCNAMEEE, MD, Bradenton, FL; University of Pennsylvania School of Medicine, Philadelphia, PA, 1935; age 78; died August 3, 1988; member OSMA and AMA.

CARL J. PFAHL, MD, Cleveland; Loyola University Stritch School of Medicine, Maywood, IL, 1943; age 74; died August 20, 1988; member OSMA and AMA.

CLYDE S. ROOF, MD, Cincinnati; University of Cincinnati College of Medicine, 1928; age 88; died September 7, 1988; member OSMA and AMA.

ROBERT A. THOMAS, MD, Mt. Victory; Ohio State University College of Medicine, 1947; age 67; died July 30, 1988; member OSMA and AMA.

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Office Staff Can Help in Risk Reduction

Since much of the contact between a patient and the doctor's office is made through the office staff, the effectiveness of this communication can promote patient satisfaction . . . or complicate matters further if the patient already is dissatisfied. In many instances, the entire office staff is involved in patient contact. For this reason, a staff that is properly trained and educated can help protect a physician from malpractice claims.

These staff-related factors include three major areas: telephone contact; scheduling of patients; and personal/professional issues. Here are several recommendations to help physicians evaluate their office practices for risk reduction.

Telephone Contact

— It is important to document all phone conversations, including after-hours calls. Should you become involved in a malpractice lawsuit, your defense may rest on the information, advice or directions you gave a patient by telephone, including after-hours and weekends. The same standard of care exists 24 hours a day.
— Build in call-back periods during your daily schedule so that the staff can inform patients when you will be able to return phone calls.
— Ask your answering service to identify itself as the service. Patients resent describing their medical situation to someone they assume is your staff, only to find they have been talking to an answering service.
— Ask your staff to limit the amount of time patients are put on hold.
— Instruct the staff on which type of calls require immediate attention by the doctor.
— Remind your staff to retain telephone message logs just as you would retain medical records.

Scheduling of Patients

One of the most frequent complaints of patients is the length of waiting times in the doctor's office. This can become one of the factors — beyond medical care — that irritates an already dissatisfied patient to the point that he will file a lawsuit.

— Ask your staff to update patients regularly about the length of waiting times. If the wait will be unexpectedly long, offer the patient a choice of waiting or rescheduling.
— Try to analyze your scheduling and have staff record the amount of "patient waiting" times to uncover and solve problem areas.
— Notify your staff if you will be delayed or late in starting your office hours. The staff can phone patients to advise them of these delays.
— As with telephone message logs, your schedule books should be retained just as you would medical records.

Personal and Professional Issues

— Clearly instruct the staff about the amount, type and limitations of advice the staff can relate to patients. You may occasionally want to monitor these responses. At times, the staff — without having heard the doctor's conversation with the patient — will give an instruction such as "The doctor wants you to . . ." which may conflict with your directive. You may not even hear this if you are busy with the next patient

Loss Awareness...*continued*

. . . but it only causes confusion.

— Give verbal feedback — both constructive/positive and negative — in a timely manner.

— Be certain that your staff is not overprotective of your time and that they do not place a barrier between you and the patient.

— In hiring staff, always verify licenses and check references. Consider setting a policy that violation of the standard of care is grounds for termination.

— Select staff who demonstrate good patient relations skills, which should be evaluated on a regular basis.

— Have written position descriptions to lessen errors in job responsibilities and to prevent staff from performing tasks beyond duty limitations.

— Instruct the staff to report any patient dissatisfaction with medical care or billing problems. Both medical and non-medical issues can tip the scales for a patient who is about ready to trigger a malpractice action against his doctor.

A staff that clearly understands the physician's practice pattern can be of immeasurable help in maintaining good contact with patients. Feedback between doctor and staff — in an open, constructive and timely framework — is essential to ensure that significant problems do not exist beneath the surface. For this reason, it is also important to encourage staff to bring to your attention and to question any possible errors that could result in patient injury. **OSMA**

The Loss Awareness Bulletin is provided each month through the OSMA Task Force on Professional Liability and its subcommittee on Loss Awareness.

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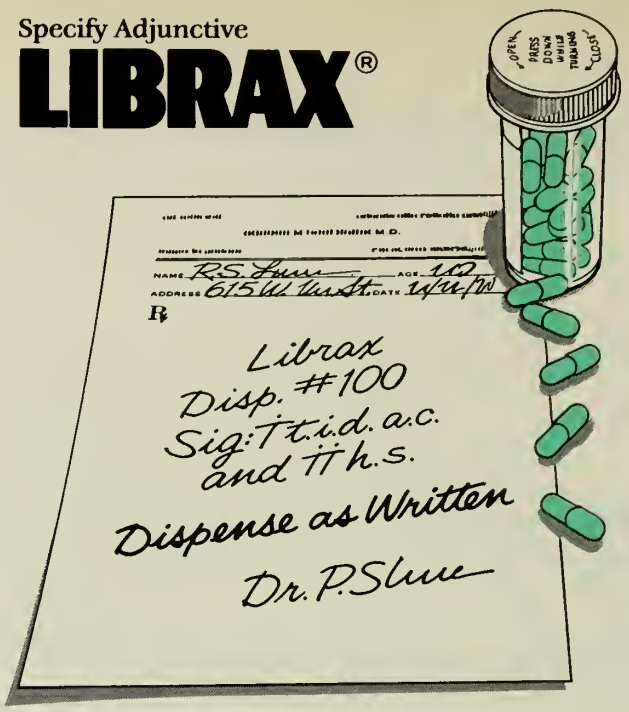

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Please consult complete prescribing information, a summary of which follows:

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
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Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).
Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**
As with all anticholinergics, inhibition of lactation may occur.
Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).
Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.
Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.
Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

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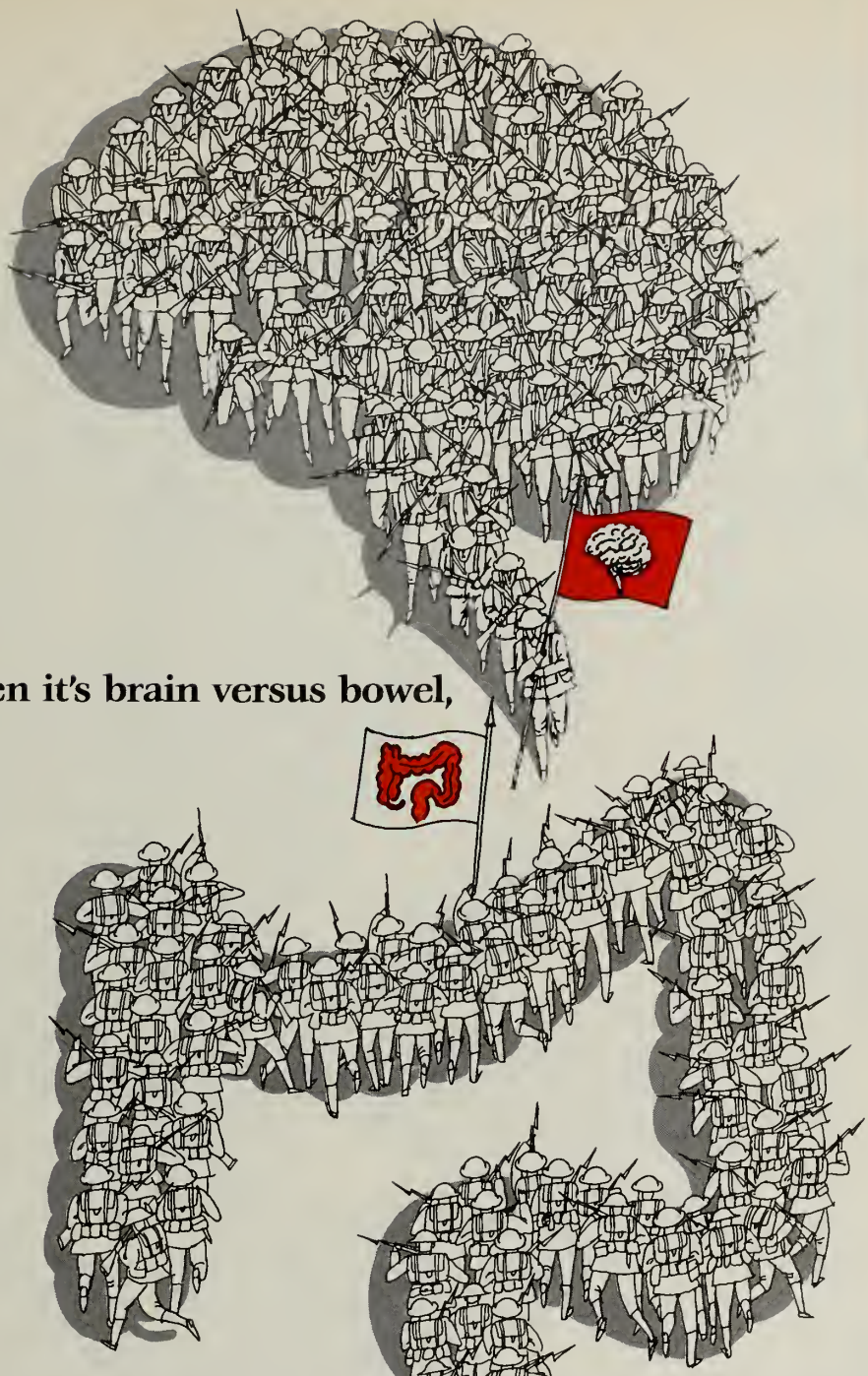

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OUT OF PRACTICE

Photo by Larry Hamill

The Bruise Brothers (l. to r.): Dennis Smith, lead vocals; Bob Falcone, MD, bass; Anne Miller, MD, keyboard; Wally Adamson, MD, drums; and Tom Baxter, lead guitar. (It should be noted that "Out of Practice" is a regular feature in **OHIO Medicine** *and does not refer to the status of the band.)*

Rock 'n' Roll: Just What the Doctor Ordered?

"If you would have asked me five years ago if I wanted to be a rock 'n' roll star, I would have said no," says Wallace Adamson, MD, drummer for the Columbus-based band, the Bruise Brothers.

And to tell the truth, says the director of the Grant Fitness Center in Columbus, "I would have never imagined that it's gone as far as it has."

Just how far has it gone? Let's just say that the license plates on Dr. Adamson's car read, "Rock MD."

It all started at a talent show for residents at Grant Hospital in the spring of 1987. "I've been accused of starting the whole thing," admits Dr. Adamson, "because I went out and bought a new drum set before the show."

Or maybe it was because his friends "knew I had something ridiculous like this in me," he says.

In any case, the talent show launched a type of music that has seldom been heard before. There's been folk rock, country rock, glitter rock and even punk rock — but no one had really ever heard of . . . physician rock.

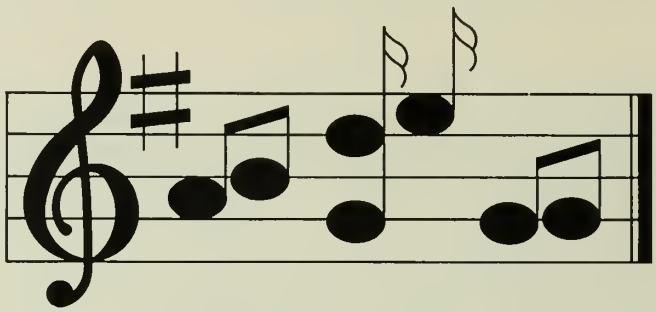
While no prizes were given at the talent show that day, Dr. Adamson says, "Far and away, based on crowd response, we won. But that's just personal opinion."

Anne Miller, MD, a Columbus plastic surgeon, saw the band perform in the show. They had a good sound, a good mix of rock 'n' roll covers. But maybe, just maybe, they were missing a small, but important ingredient — a keyboard.

The keyboard added an extra dimension to the '60s musical sound; it was an instrument that could run the gamut from a church-like drone to the sound of a creaky door slowly opening.

After all, where would the

By Deborah Athy



opening of the song "Light My Fire" be without the classic keyboard lead-in by Doors musician Ray Manzarek? Or consider the keyboard sound in "A Whiter Shade of Pale," a song that's found a wider shade of success since "The Big Chill" era.

Perhaps that's the sound Dr. Miller had in mind when she crashed one of the band's practice sessions with an instrument in tow. "I showed up one time at practice with keyboards," she says — and the rest is history.

The name for the band came from a brainstorm session in which the members "sat down and went through doctor-related names," remembers Dr. Adamson. A play on the name of the band, The Blues Brothers, along with a little medical flavor led to the band's billing as The Bruise Brothers.

Other band members include lead vocalist and rhythm guitarist Dennis Smith, vice president of Ancillary Services at Grant Hospital; lead guitarist and backup vocalist Tom Baxter, former program director of Grant's LifeFlight program; and on bass and vocals, Robert Falcone, MD, director of LifeFlight Trauma Services.

The band started out wearing dark glasses and skinny ties, but anymore the band members are just as likely to present a mixed bag of fashion statements — from jeans and Blues Brothers T-shirts to hospital scrubs. "If the occasion calls for it, we can get tuxedoes from the Salvation Army and Good Will," Dr. Adamson adds.

The band dishes out a classic mix of tunes from the '60s grab bag: "Gimme Some Lovin'," "Warm California Sun," "Gloria," "Please, Please Me," "Twist and Shout" and "Honky Tonk Woman," to name a few.

"I'm a real fan of rock 'n' roll," says Dr. Miller. "I grew up with it." In fact, most of the songs that the band performs can be found in her own personal record collection.

Most people in their 30s and 40s identify with this kind of music, she continues. "They want to hear songs that they know."

Dr. Adamson has also been a long-time fan of rock 'n' roll. "I've been playing drums since the seventh grade and then continued playing after that," he says. He played in a basement band — sometimes called a garage band — while attending Miami University. The band played mostly for friends and fraternities, but Dr. Adamson had to pack up his drum set when his medical residency began to require all of his attention.

Rock 'n' roll is the band's strong suit, but the Bruise Brothers are also partial to dance tunes — selections such as "Locomotion" and "Hang on, Sloopy" that never fail to fill up a dance floor.

The Bruise Brothers also play some numbers with a more contemporary beat, including a melody from "Dirty Dancing." The band is currently at work on some original material scheduled to be released on a single in the spring.

The Bruise Brothers have played a number of gigs since they first got together. Dr. Miller says they would also enjoy giving other physicians a dose of their music at staff parties or other medical gatherings.

The most fun that Dr. Adamson ever had onstage was when the band played outside on a cold, rainy day. "The band played at a barn in Lancaster, Ohio, and it was 30 degrees and raining," he remembers. But his son, Dylan — the band's number one fan — was there dancing around with a pair of drumsticks, really enjoying the music. "That was the most fun," Dr. Adamson says. "I was really playing for him."

The band gets together once or twice a week for a jam session. "For me it's a night out," says Dr. Adamson. "I don't have to worry about calls. It's a good stress release more than anything."

"It's a lot of fun," says Dr. Miller. "We all enjoy each other's company." And besides, the music is a release, she agrees. "It's something totally different than thinking about medicine."

And while medicine and rock 'n' roll are worlds apart by most standards, the two occasionally do meet. "It's a running joke," says Dr. Adamson, of those patients who ask him for Bruise Brothers T-shirts and tapes.

And for Dr. Miller, music and medicine sometimes meet in the operating room, of all places. In fact, sometimes a little dose of rock 'n' roll is just what the doctor orders when she operates. Although she admits that on occasion she has been asked to turn the music down.

Apparently, once you've caught the rock 'n' roll fever, it can be hard to find a cure.

"Everyone has a streak in them that dreams of being an artist, whether it's painting or music or whatever," Dr. Adamson explains. "Mine has always been music." **OSMA**

Deborah Athy is Associate Editor of **OHIO Medicine.**

Strength in Numbers

OSMA membership, then and now

By Katherine E. Wisse

In the 1800s OSMA membership was less than 1,000 members. Membership jumped from 655 in 1902 to 2,278 the following year and has increased steadily with 20,925 members in 1988.

It is interesting to note that 19% of OSMA members served in the military in World War I (873 of a total membership of 4,692). In World War II that participation was 29% (1,996 of a total membership population of 6,906).

In those days, membership consisted of active members only. In 1978, residents and medical students started joining. The change in membership composition between 1980 and 1988 is strikingly evident in Figure 1.

The addition of 3,084 students and 3,191 residents as well as 1,238 active members swelled the membership to 20,925 in 1988.

It is apparent that our medical student and resident members contribute significantly to OSMA's strength in numbers.

Figure 2 shows the total membership of both OSMA and AMA from 1980 to 1988.

Two groups that are important segments of our membership are the FMGs and female physicians. Figure 3 shows the number of FMG and female members of OSMA. The FMGs represent 20% and the women represent 14% of OSMA's total population.

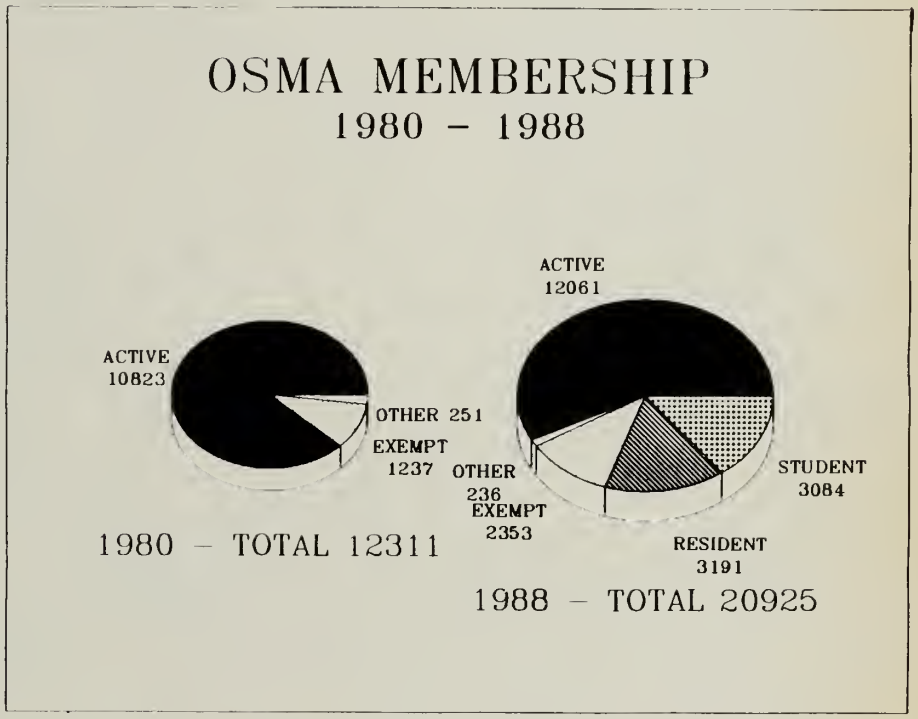


Figure 1

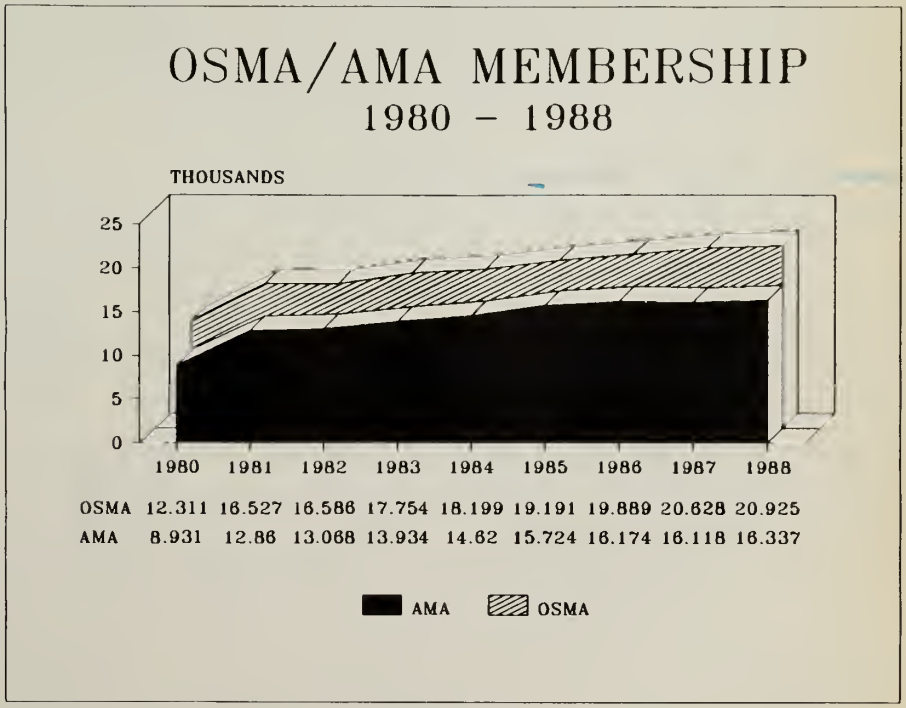


Figure 2

Another significant number are the young physicians, some of which are included in the above groups. Almost one-third of OSMA active members are in this category.

How many physicians are out there who do not belong to organized medicine? The latest figure we have from the Medical Board is that there are 21,047 physicians licensed in Ohio. A comparison of our membership with this population, excluding medical students, is shown in Figure 4. Our 17,841 members represent 84.8% of the licensed physicians in Ohio.

OSMA's FMGs and female membership is also high, 71% and 56% respectively. (See Figure 4.)

The specialty societies are another source of potential members. According to the AMA, the following specialties in Ohio have more than 1,000 physicians in that specialty:

General Practice	12.5%
Internal Medicine	15.6%
Pediatrics	6.9%
General Surgery	7.4%
Obstetrics and Gynecology	5.7%
Anesthesiology	4.7%
	52.8%
All others	47.2%
	100.0%

The OSMA Committee on Membership continues to monitor county, OSMA and AMA membership and seek ways to increase that membership. It is actively engaged in identifying and segmenting nonmembers for recruitment purposes. Its goal is to have many physicians join their voices with the 20,925 members OSMA already has to increase the strength in numbers as medicine faces the many challenges ahead. **OSMA**

Katherine E. Wisse is the Director of OSMA's Department of Membership Development.

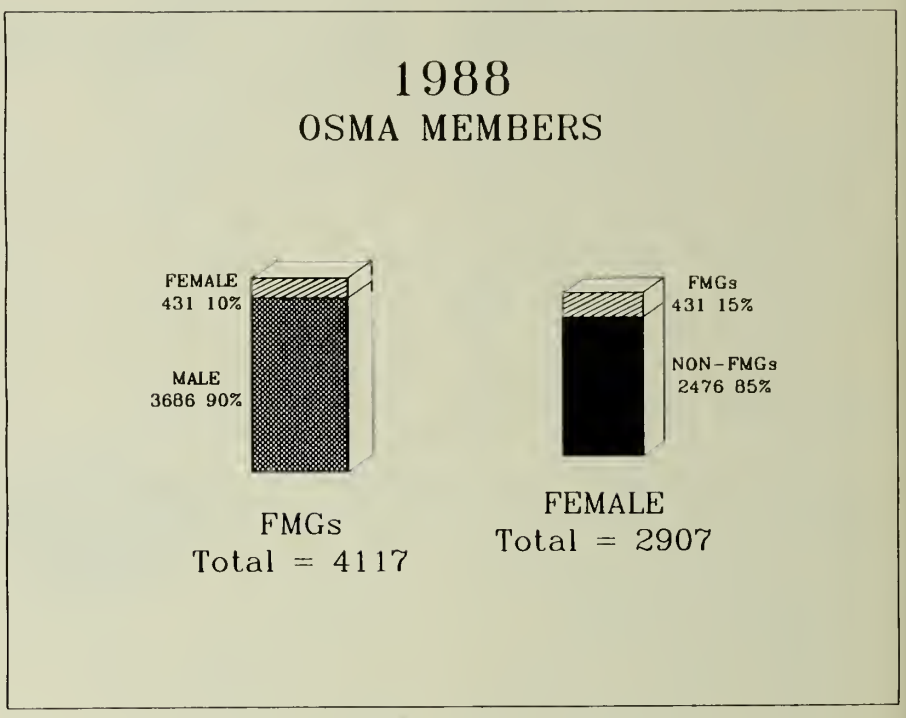


Figure 3

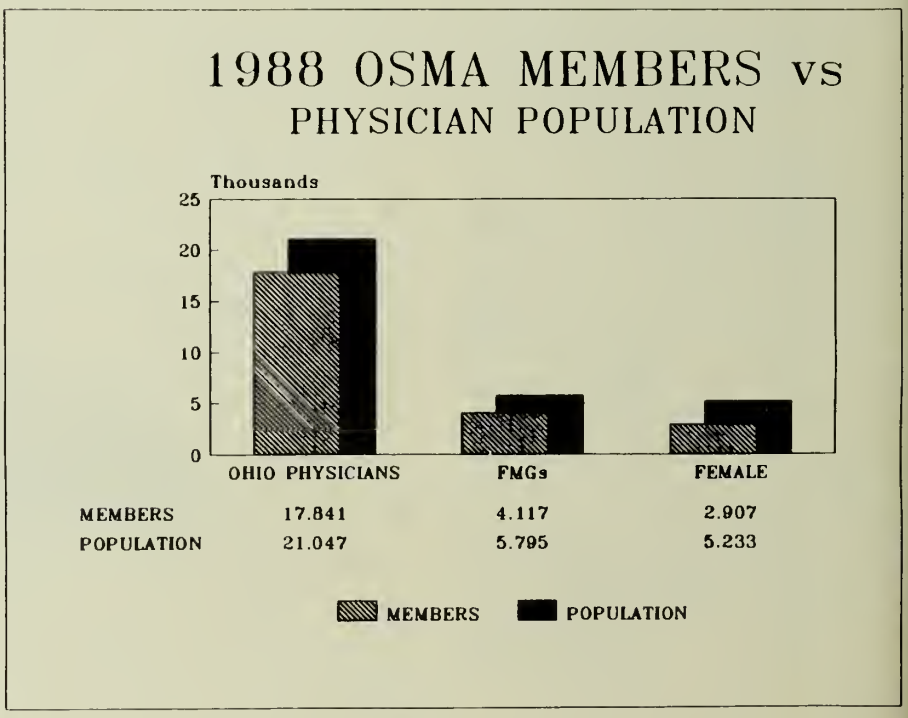


Figure 4

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VASOTEC is available in 2.5-mg, 5-mg, 10-mg, and 20-mg tablet strengths

Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: *Angioedema:* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Heart failure patients given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. If may be advisable to eliminate the diuretic (except in heart failure patients), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: *General: Impaired Renal Function.* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia. Elevated serum potassium (> 5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See *Drug Interactions.*)

Surgery/Anesthesia. In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients:

Angioedema. Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension. Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure, patients should be advised to consult with the physician.

Hyperkalemia. Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia. Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE. As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions.

Hypotension: Patients on Diuretic Therapy. Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents. VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. Although a causal relationship has not been established, it is recommended that caution be exercised when lithium is used concomitantly with VASOTEC and serum lithium levels should be monitored frequently.

Pregnancy — Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not been clearly defined, VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome. Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity.

Nursing Mothers. Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION. The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE. The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category.

Cardiovascular. Cardiac arrest, myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*), cardiac arrest; pulmonary embolism and infarction; rhythm disturbances, atrial fibrillation, palpitation.

Digestive. Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis.

Nervous/Psychiatric. Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital. Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

Respiratory. Bronchospasm, rhinorrhea, asthma, upper respiratory infection.

Skin: Herpes zoster, pruritus, alopecia, flushing, photosensitivity.

Other. Vasculitis, muscle cramps, hyperhidrosis, impotence, blurred vision, taste alteration, tinnitus.

A symptom complex has been reported which may include fever, myalgia, and arthralgia; an elevated erythrocyte sedimentation rate may be present. Rash or other dermatologic manifestations may occur. These symptoms have disappeared after discontinuation of therapy.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension. In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings

Serum Electrolytes. Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit. Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g % and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown). In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported.

Liver Function Tests. Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: *Hypertension.* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment. The usual dose of enalapril is recommended for patients with a creatinine clearance >30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤30 mL/min (serum creatinine ≥3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure. VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, *Pharmacodynamics* and *Clinical Effects.*) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Heart Failure Patients with Renal Impairment or Hyponatremia. In heart failure patients with hyponatremia (serum sodium <130 mEq/L) or with serum creatinine >1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, *Heart Failure*, WARNINGS, and PRECAUTIONS, *Drug Interactions.*) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

For more detailed information, consult your MSD Representative or see Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486. J6VS18R2(817)

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COUNTY COLLECTION

County scholars

As schools gear up, once again, for the start of another academic year, how appropriate to take a look at those scholars whose interest in science — at a time when interest in science is reportedly at an all-time low — earned them special recognition from the medical societies in their respective counties. Listed below are a handful of these students who make medicine's future look bright, indeed.

Health reporters

Every year, Columbia University in New York presents its annual Columbia Scholastic Press Association's Gold Circle Awards. This year was the second year the American Medical Association became involved in the journalism competition by distributing its own Health Reporting Award to students whose articles on health topics, published in their student newspaper, were exemplary.

Among this year's Health Reporting Award winners were four from Ohio:

Erin Krasik and Michael Mushrush, both of Upper Arlington High School, Columbus, Ohio, won a first-place award and $250 for an article they wrote on the children of alcoholics for their school magazine *The Upper Arlington Arlingtonian.*

James J. Powers, MD, past president of the Academy of Medicine of Columbus, recognizes AMA Health Reporting Award winners Erin Krasik and Chad Kister, both students at Upper Arlington High School in Columbus.

Also receiving a third-place award from the AMA was Chad Kister, also of Upper Arlington, a general health reporter, whose stories touched on such subjects as steroids and teen-age abortion.

All three students were recognized by the Academy of Medicine of Columbus and Franklin County at a special spring meeting.

Also receiving one of the AMA's Health Reporting awards was Derrick Cain, a student from Kirkland High School, Kirkland, Ohio, who received a second-place award in the high school health news category.

Science fair winner

Last month, *OHIO Medicine*'s "Ohio Medi-scene" section reported on the State Science Day competition, which is held each year on the Ohio Wesleyan University Campus in Delaware. The Ohio State Medical Association honors those students whose studies and resulting exhibits in the medical field deserve special recognition. A student from each grade level (seventh through 12th) receive framed certificates, and an overall winner receives a plaque and a $100 U.S. Savings Bond.

This year's award winner was

County Collection . . .

County Scholars . . . *continued*

Rolf N. Barth, a senior from Upper Arlington High School, Columbus.

Barth was recognized by the Academy of Medicine of Columbus and Franklin County at the same spring meeting which honored the three area's Health Reporting Award winners.

Ann Clinger, Deputy Executive Director of the Columbus Academy, believes it's important for county medical societies to involve themselves in recognizing such student achievement.

"Whether the students are involved in reporting or researching health topics, they are promoting the field of medicine, and that's important for our future," she says. "After all, the students today *are* our future."

Ronald B. Berggren, MD, Chairman of the Columbus Academy's Educational Foundation, recognizes this year's State Science Day award winner, Rolf N. Barth, a senior at Upper Arlington High School in Columbus.

Roster of scholars

Since 1966, the Mahoning County Medical Society has been honoring those students in its community who display academic achievement and scholastic excellence at a special scholarship recognition dinner, which the society holds every April.

"We leave the selection of students up to the schools," says Eleanor Pershing, the society's Executive Director. "They don't have to be science students, although it generally turns out that at least half of them are interested in pursuing a career in medicine."

This year, the society honored 70 students from 25 area high schools.

"One or two students will come to the dinner as representative of their school," Pershing continues, "but all of the student honorees receive a pin and certificate."

To make each student feel welcome, a host couple, consisting of a society member and spouse, are seated at each table with the students to offer congratulations and promote the interchange of ideas between physician and student. Typically, a speaker will address the students following dinner.

"Sometimes we call on society members, other times we use outside speakers," says Pershing.

This year, however, society members and students alike were surprised by an impromptu speech, given by Ohio Governor Richard Celeste.

"He happened to be at the same inn where our dinner was being held," Pershing explains. "He was attending a private dinner, and learned we were there. He just came in and offered to say a few words to the students."

According to Pershing, the Roster of Scholars tradition was not designed, necessarily, to promote an interest in science or medicine.

"It's just a way for our members to get involved in the community and to recognize those students who are doing a good job. It's one of those events our members — and the students — look forward to every year." — *Karen S. Edwards*

Stark County's "Washington Fly-In" a success

The Stark County Medical Society recently held its second one-day, fly-in trip to Washington D.C. More than 30 physicians and spouses participated in the trip.

The day began at 7:00 a.m. at the Cleveland Hopkins Airport. The participating Stark County physicians and their spouses boarded the plane and arrived in Washington by 8:30 a.m. to meet with congressman and Mrs. Ralph Regula (R-Ohio) for their first seminar of the day. Later that morning, the group met with a representative from the Health Care Finance Administration (HCFA). The physicians posed many pertinent questions concerning recent changes physicians have experienced in their practices.

The luncheon speaker was Ohio's Sen. John Glenn, who discussed his feelings concerning the medical profession. Sen. Glenn stated that he had once considered becoming a physician, but World War II and other reasons caused him to opt against becoming one. However, he added that his son did follow that dream, and is now a practicing physician. Sen. Glenn frequently hears from his son, and other physicians, about their concerns practicing medicine in Ohio — as well as other regions of the country.

With congressman Regula's assistance, the following speakers also addressed the Stark County group on their views of some of the health-care-related changes which may occur during this Congress:

Congressman Henry A. Waxman, (D-Calif.) discussed his universal health-care bill. Congressman Fortney H. "Pete" Stark, (D-Calif.) briefly touched upon his controversial patient referral bill, then switched to a safer topic — reducing paperwork for physicians by developing a way to code Medicare charges by telephone. Congressman Willis D. Gradison (R-Ohio) spoke openly about potential changes in Part B Medicare. Congressman Edward Madigan (R-Ill.) also addressed the group on health-care issues.

During the breaks between speakers, congressman and Mrs. Regula opened the floor for discussion. The congressman wanted the physicians and their spouses to express their views on what they see happening to patients in the district, as well as their feelings on recent changes in the practice of medicine. The Stark County contingent voiced their thoughts and concerns both openly and honestly on the direction medicine is taking. This open discussion also allowed the physicians and spouses a somewhat better understanding of how complicating and frustrating the legislative process can sometimes be for members of Congress.

Each person in attendance left that day with a better understanding of the federal legislative process. They also learned that they can work together, with their representatives, to bring about better legislation for organized medicine. — *Kathy Wehe*

Sen. John Glenn expresses some ideas about the medical profession.

Society members meet with government representatives during the trip.

If you would like to organize a similar trip for your medical society, you may contact Kathy Wehe, OSMA Federal Key Contact Coordinator at (614) 486-2401. Also, if you have any questions specifically pertaining to Stark County's fly-in trip, you may contact Nancy Adams, Director of the Stark County Medical Society, 4942 Higbee Avenue, N.W., Suite L, Canton, OH 44718, (216) 492-3333.

County Collection . . .

Trumbull County's proclamation

Mother's Day . . . Father's Day . . . Secretary's Day . . . Sweetheart's Day . . .

These days, it seems, hardly anyone escapes the notice of well-intentioned public relationists and greeting card manufacturers, so it seems only fair that doctors, too, have their own special date on the calendar — March 30.

According to sources, Doctor's Day has been celebrated since 1933 to commemorate the efforts of Crawford W. Long, MD, Jefferson, Georgia — the physician credited with discovering the use of ether for painless surgery. Traditionally, physicians observe the day by wearing red carnations.

Although *OHIO Medicine* missed recognizing this year's official Doctor's Day, Daniel Sferra, the mayor of Warren, in Trumbull County, did not.

On the official day itself, he presented the Trumbull County Medical Society with the following proclamation:

"Whereas the Trumbull County Medical Society has been faithfully serving the community in numerous public-oriented projects; and

Whereas, as a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals and to self; and

Whereas, the following principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician; and

Warren Mayor Daniel Sferra (l.) recognizes Doctor's Day with Robert Taylor, MD (center) and Howard Adelman, MD (r.)

Whereas a physician shall be dedicated to providing competent medical service with compassion and respect for human dignity; shall deal honestly with patients and colleagues, and strive to expose physicians deficient in character or competence, or who engage in fraud or deception; shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient; shall respect the rights of patients, of colleagues and of other health professionals, and shall safeguard patient confidences within the constraints of the law; shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues and the public, obtain consultation, and use the talents of other health professionals when indicated; shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services; shall recognize a responsibility to participate in activities contributing to an improved community;

Now, therefore, I, Daniel J. Sferra, mayor of the city of Warren, Ohio do hereby proclaim Thursday, March 30, 1989 as "Doctor's Day" and urge all citizens and community leaders in Warren, Ohio to recognize the contributions of our physicians and the Trumbull County Medical Society."

A nice gesture to be sure . . . and to doctors everywhere *OHIO Medicine* offers its own recognition for a job well done. — *Karen S. Edwards*

Physicians' quality of life studied

If you're a physician practicing in Montgomery County, chances are good that you're a married, white male who is satisfied with the medical profession.

At least, that's what the data from a Montgomery County Medical Society questionnaire indicates. The society recently published partial results from its poll, which was sent to 850 Dayton area physicians, in *Dayton Medicine.*

Nearly 50% of the physicians answered the questionnaire, which was aimed at determining the quality of the work life of practicing physicians.

The general characteristics of the respondents indicated that the majority are white, married males, and that half earn between $76,000 and $150,000 a year, after taxes.

The study also showed that the majority of the physicians seem to be satisfied with their work:

- 90% think that their professional skills will still be useful in the next five years.
- 85% say their work meets their expectations.
- 75% say they feel rushed while working.
- 65% think there is a surplus of physicians in the Dayton area.

Despite the heavy workload of the average physician, the majority of Dayton practitioners indicated that they manage to find time for leisure activities:

- 80% watch television frequently.
- 60% sometimes read newspapers, books or magazines.
- 60% frequently exercise.
- 70% work around the house or yard for pleasure.
- 60% frequently visit friends.

While most physicians indicated that they are very happy with their family life, many said they regret not having more time to participate in family activities:

- 80% are very satisfied with their family life.
- 70% spend most of their free time with their family.
- 70% would like to spend more time with their family, even if it means a drop in income.

Overall, the society concluded, the response of Dayton physicians indicates a high degree of satisfaction with the medical profession, social and leisure activities, and family life. The final results of the study are expected to be published in an upcoming issue of *Dayton Medicine. — Michelle J. Carlson*

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Total Joint Replacement: Both a Miracle and a Disappointment

Thomas H. Mallory, MD, FACS
Steven Knezevich, MD

Total joint arthroplasty has become a successful therapy for patients with debilitating arthritis of the major weight-bearing joints. However, by current standards, the life of a total joint implant is approximately 10 to 15 years. Older, more sedentary patients enjoy greater and longer-term success than younger, active patients. Eventually, most implants fail because of component loosening. Currently, efforts to obtain longer-term implant stability are focused on achieving bone growth into the implanted components. A new process of plasma-spraying hydroxyapatite — an entirely biocompatible, bioceramic material — onto porous, titanium alloy components promotes bone ingrowth into the components resulting in implant fixation, which is superior to current methods of cemented or cementless fixation. Early results suggest that hydroxyapatite-bioingrowth fixation may be the start of a new era in joint implant surgery.

Introduction

These could be called the "best of times and the worst of times" for joint replacement. While the technology for total joint replacement represents a true miracle for most patients, for others it has been at best a disappointing solution to a debilitating problem.

The technology of total joint replacement has evolved from a variety of designs of cemented and uncemented components, all of which attempted to achieve long-term stability of the implanted components. Current efforts to achieve greater long-term stability involve the use of synthetic hydroxyapatite, which has been shown to promote bioingrowth of bone tissue into the implant. While this technique appears promising, only time will tell if it does indeed lead to stable bioingrowth and greater long-term stability.

Factors Affecting Prosthetic Implant Quality

When discussing the issues of quality, it is important to place in perspective what is good and unique about the concept of joint replacement. Simplistically, joint replacement creates a Charcot joint phenomenon. With the use of mechanically fixed, nonviable surfaces, pain relief is consistently achieved. In fact, one could say that it is beyond a measurable alternative.[1,2,3] Alternatives to joint replacement, if they do exist, are essentially unimpressive.[4,5,6,7] Current emphasis is directed toward creating a better joint replacement system that will achieve longevity. What issues affect the longevity of a prosthesis? There are two areas of critical concern: 1) the quality of the materials, and 2) the complex interface that develops between the prosthetic unit and the surface biology.[8,9,10,11]

Materials. Presently, hip replacement composite materials will withstand 15 years of activity in a biologic environment, if the individual is moderately sedentary. The metal alloys of titanium or chrome cobalt work well with the proper design.[12] Polyethylene plastic cups perform well for an average of 10 to 15 years. However, the material of concern in the 10- to 15-year span is polymethylmethacrylate,[8,13,14] used to fix the prosthesis

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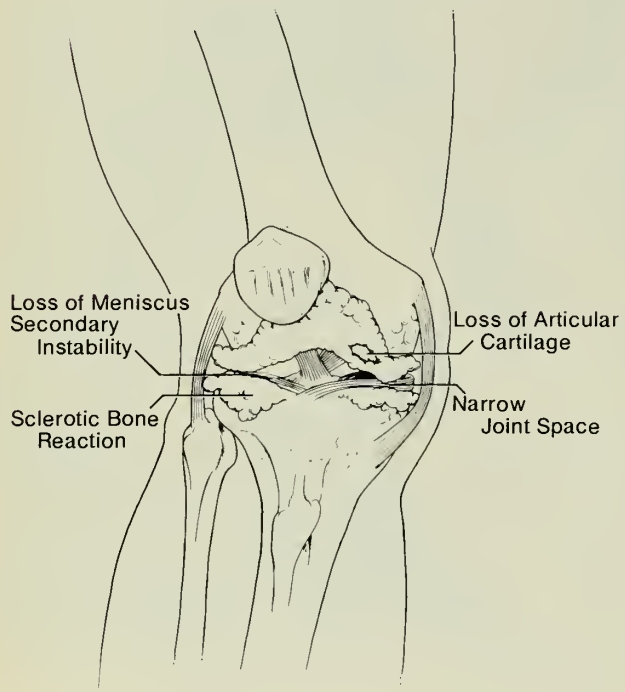

Figure 1: The osteoarthritic knee serves as a model illustrating the loss of meniscal substance and the marked reaction of the subchondral bone to overload and microfracture. Subsequent loss of articular cartilage with the resulting narrowing of the joint leads to pain, effusion, instability and marked functional loss.

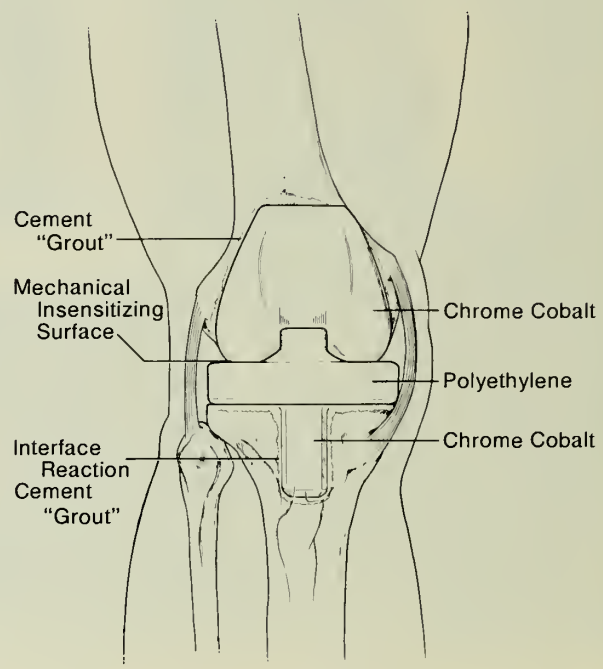

Figure 2: Joint replacement serves as a type of Charcot joint with the insensitive surfaces becoming the bearings for weight distribution. The implant combination chrome-cobalt and polyethylene plastic is held in the living tissue with grouting material, polymethylmethacrylate. Alternative methods of fixation utilizing porous ingrowth may, in time, replace bone cement as a fixing agent. However, prosthetic implants always create interface reaction despite the modes of fixation.

to the bone (Figures 1 and 2).

Basically, polymethylmethacrylate (PMMA), a long-chain polymer, undergoes an exothermic setting process *in vivo.* During the setting process, it changes from a relatively molten and doughy consistency to a firm, rigid, brittle material. This setting process allows the PMMA to create a "micromodel" of the interstices of the bone. The finger-like appendages of PMMA interdigitate nicely within the bone trabeculae, creating a very rigid fixation.

Interface. The interface between the bone and cement undergoes various phases in its maturation.[11] The first phase is the trauma reaction. Exothermic reaction of the PMMA and the physical interaction between this material and the bone itself creates a trauma effect, which requires a period of recovery. During this recovery, all of the processes of wound healing are active (e.g., removal of necrotic debris, the establishment of a vascular matrix and the maturation of fibrous tissue). Given the best of circumstances, a fibrous interface develops between the bone and the PMMA, which is devoid of any particular cellular consistency. The interface will remain essentially quiet for an indefinite period of time, as long as there is minimal micromotion of the prosthetic components, the lack of local fracture of the bone trabeculae and the absence of accumulated wear debris (Figure 3).

However, whenever motion or fracture of the bone trabeculae occurs or when wear debris is present, a rather radical and drastic change in this interface occurs.[15,16] Macrophages and mast cells invade the interface[13,17,18] and release enzymatic constituents such as prostaglandin E2, collagenases and interluken II. These enzymatic agents act to engulf or incorporate the debris. However, they create an osteolytic reaction on the bone itself,[10] causing a widening or expanding of the interspace between the bone and the prosthesis. Thus, with continued load and activity, a cycle is created that is self-perpetuating. The disaster occurs when large amounts of caseous-like material are deposited within the interface and the osteolysis progresses to a point at which marked loss of bone occurs (Figure 4). It has been illustrated on numerous occasions that when this type of reaction does in fact occur, the interface is vulnerable to secondary seeding of bacteria.[19] The coexistence of occult sepsis becomes a very real concern.

There are several factors that influence the development of the adverse interface. First, the type of patient. A relatively sedentary individual is the best candidate for total joint replacement. Weight, activity and functional demands placed on the

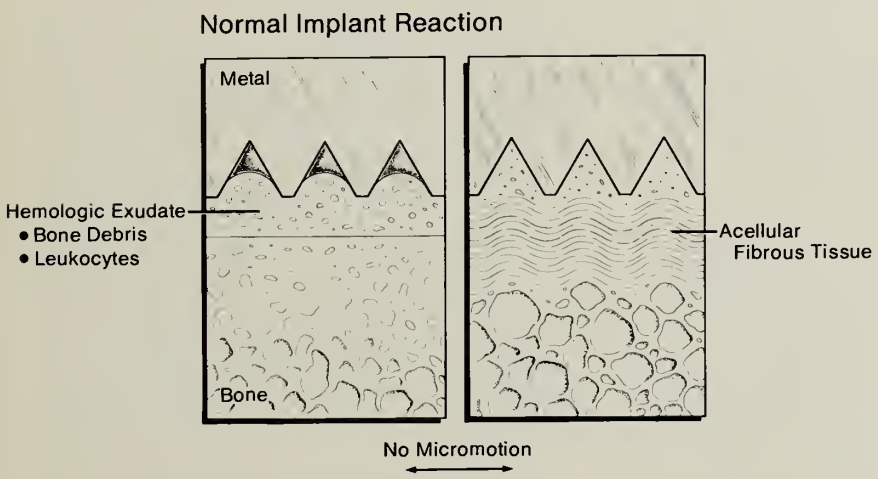

Figure 3: Normal implant reaction. Rigid fixation of implant against biologic surfaces leads to the development of a quiescent fibrous interface.

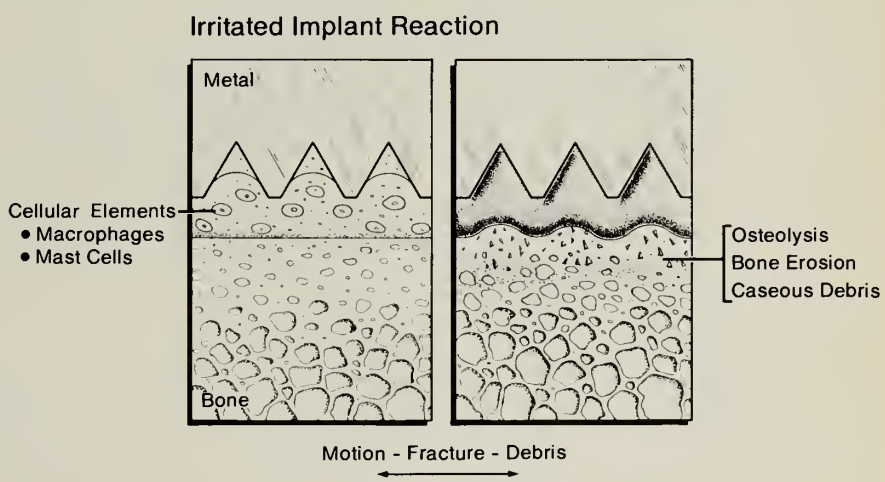

Figure 4: Irritated implant reaction. Presence of micromotion as a result of the implant moving against living bone leads to an inflammatory reaction. The invasion of macrophages and mast cells and the subsequent release of enzymatic substances lead to osteolysis, chrondrolysis and subsequent bone erosion.

prosthetic system create the problem of microfracture, wear debris and prosthetic motion. Even with the most sedentary individual, there is a gradual and continuous attrition at the interface. Interface dissociation will always be inevitable and, given the passage of time, all prosthetic devices will eventually loosen. The existing issues, therefore, center around the patient's lifestyle *and* life expectancy, versus the prosthetic system's longevity.[20]

Efforts to Develop Alternative Methods of Fixation

Cementless fixation in total joint arthroplasty has drawn interest in response to reports of component loosening in cemented total hip arthroplasty as high as 30% to 40% after 10 years.[10,18] The failure of PMMA to maintain a long-term interface has led to the development of cementless fixation techniques,[12,21,22,23,24,25] in which methylmethacrylate is eliminated as a fixing agent. The prosthetic components are laid against the biologic surface, anticipating that there will be an osseous integration process. This had led to a completely new and exciting awareness of the biologic reaction to various materials (metal, plastic and ceramic).

A porous lattice surface is created on the structures of the various materials, which serves as an osteoconductor for the bone.[26] Vascular pedicles grow into the lattice structure, and interwoven laminar bone develops. In the animal model, the microingrowth of bone into implants is quite impressive.[23] In humans, there is some question as to the predictability and viability of bone-porous ingrowth. Clinical studies, however, are encouraging, and indicate that a process does exist whereby one can, given the right circumstances, create an excellent microingrowth interface with a porous metal surface.[24,25,27,28]

Hydroxyapatite in Cementless Fixation

Hydroxyapatite and tricalcium phosphate are two members

of a class of porous minerals composed of calcium and phosphate, often called bioceramics. These materials are entirely biocompatible and osteoconductive. A direct bond has been shown to form between the porous mineral and the ingrown bone without any intervening fibrous tissue,[1,2,8,12,23] and with a bond strength that may be as great or greater than cortical bone itself.[23] Early clinical interest in these materials centered upon their use in reconstruction of traumatic skeletal defects[3,12,16,17,27] and in oral and maxillofacial reconstructive surgery.[21,26] However, the brittle ceramic nature of the pure compound predisposes it to failure under conditions of load-bearing.

More recently, hydroxyapatite has attracted interest as a method of cementless fixation of prosthetic components in total hip arthroplasty. Hydroxyapatite has the chemical formula ($Ca_{10}[PO_4]_6[OH]_2$) and represents the predominant form in which calcium and phosphate are found in human bone. The synthetic hydroxyapatite form of calcium phosphate closely resembles its counterpart in the vertebrate skeleton, and has virtually the same crystallographic structure. Hydroxyapatite is also found in coral, the limestone skeleton of various species of marine invertebrates. It has been used as a bone graft substitute in skeletal defects in both animal and human studies.[3,12,16,27] Hydroxyapatite is entirely biocompatible. Bone ingrowth into synthetic and corraline hydroxyapatite occurs by osteoconduction; its porous nature provides a scaffold with a surface environment conducive to the ingrowth of connective tissue and subsequently new bone. The hydroxyapatite is applied by either plasma spraying or sputter coating,[13] with an optimum thickness of between 30 and 90 microns.[8] Whether biologic ingrowth will be predictable and whether it will be totally applicable to the older and the problematic young individual, remain to be fully understood.

Basic Concerns

Several concerns exist with cementless fixation. First, because there is an extensive surface area of metal against living bone, the concern for corrosion and metallic debris is real.[10] Base metals, including cobalt and nickel, have been associated with sarcomatous degeneration in animal models, and occasionally in humans.[10] Whether the biologic interface will tolerate a metal surface for an indefinite period of time remains to be determined.

Additionally, the retrievability of the implant is a concern with any joint replacement. If the device needs to be removed, for reasons such as materials failure or infection, can the biologic bond be broken and the implant removed? These are very real and challenging questions.

Summary

It must be emphasized that joint replacement in the short run is highly successful, that the mechanism of the insensitive joint surface as it applied is, for the most part, quite reasonable. The biologic interface is a critical issue. The best patients for joint replacement will always be those individuals with limited activity profiles. However, alternatives are being developed to create a better interface that will achieve greater longevity of the implant, and provide a clinical solution for the non-sedentary patient population.

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OSMA notebook

Two candidates announced for 1990-1991 President-Elect position . . . Two Ohio physicians have announced their intentions of seeking the office of President-Elect of the OSMA. Herb Gillen, OSMA Executive Director, has received letters of nomination for Stanley J. Lucas, MD, Cincinnati, First District Councilor, and Joseph Sudimack, Jr., MD, Columbus, OSMA Secretary-Treasurer. Dr. Lucas, Past President of the Academy of Medicine of Cincinnati, is a radiologist whose practice is divided between solo private office and a hospital group. Dr. Lucas has actively participated both in the AMA and OSMA delegations, and has served on many OSMA committees, including the membership and legislative committees and serving as chair of the OSMA Audit and Appropriations Committee. He is in his fifth year as Councilor for the First District. Dr. Sudimack, Past President of the Trumbull County Medical Society, was in solo general practice for more than 20 years in Warren before moving to Columbus in 1987. He is presently medical director of the J. Leonard Camera Center, the Industrial Commissions's rehabilitation facility. Dr. Sudimack has served as a Delegate to the OSMA since 1976, served on numerous OSMA committees and is a Delegate to the AMA. Dr. Sudimack is in his second term as Secretary-Treasurer.

State "opts out" of medical waste program . . . This past spring, Gov. Richard Celeste announced that he was "opting out" of the federal medical waste program — an action that was taken at the request of the Ohio State Medical Association. Ohio currently has one of the best state infectious medical waste laws in the country, which includes exemptions for those generating only small amounts of infectious waste. The OSMA expressed its concern to the governor because it felt the repercussions of the federal program would have been disastrous to Ohio physicians. Under the federal regulations, physicians and their staffs would have been inundated with excess paperwork and unwielding disposal procedures and most likely would have needed to add staff to comply with the regulations. By convincing the governor to opt out, the OSMA saved members many times over the cost of annual membership dues. The OSMA's Department of Legislation would like to thank the physicians and Auxilians for their timely written responses to the governor.

Key contact program growing . . . The OSMA has received over 250 surveys from physicians and spouses who are interested in becoming key contacts. This new program is designed to keep Ohio physicians and spouses better informed of and more involved in federal legislative issues. Anyone interested in becoming a key contact may call the Ohio State Medical Association, Department of Legislation, at (614) 486-2401.

Medical writing contest . . . *OHIO Medicine* invites medical students and residents to enter our first "Medical Writing Contest." The competition is open to Ohio medical students and residents. A plaque and a $250 prize will be awarded to the medical student and resident who submits the most outstanding scientific paper, as judged by members of *OHIO Medicine*'s advisory board. The papers should be submitted between now and February 1, 1990. Winners will be announced and prizes awarded at the 1990 OSMA Annual Meeting in Cleveland, Ohio. The winning entries will also be published in *OHIO Medicine*. All entries should be no more than 10 typed, double-spaced pages in length, and should be sent to: *OHIO Medicine* "Medical Writing Contest," 1500 Lake Shore Drive, Columbus, OH 43204-3824.

Toll-free number . . . Physicians wishing to contact the OSMA on official business may now use the OSMA's toll-free number: (800) 282-2712. If busy, please use (614) 486-2401. We will be evaluating the utilization of these numbers over the next several months.

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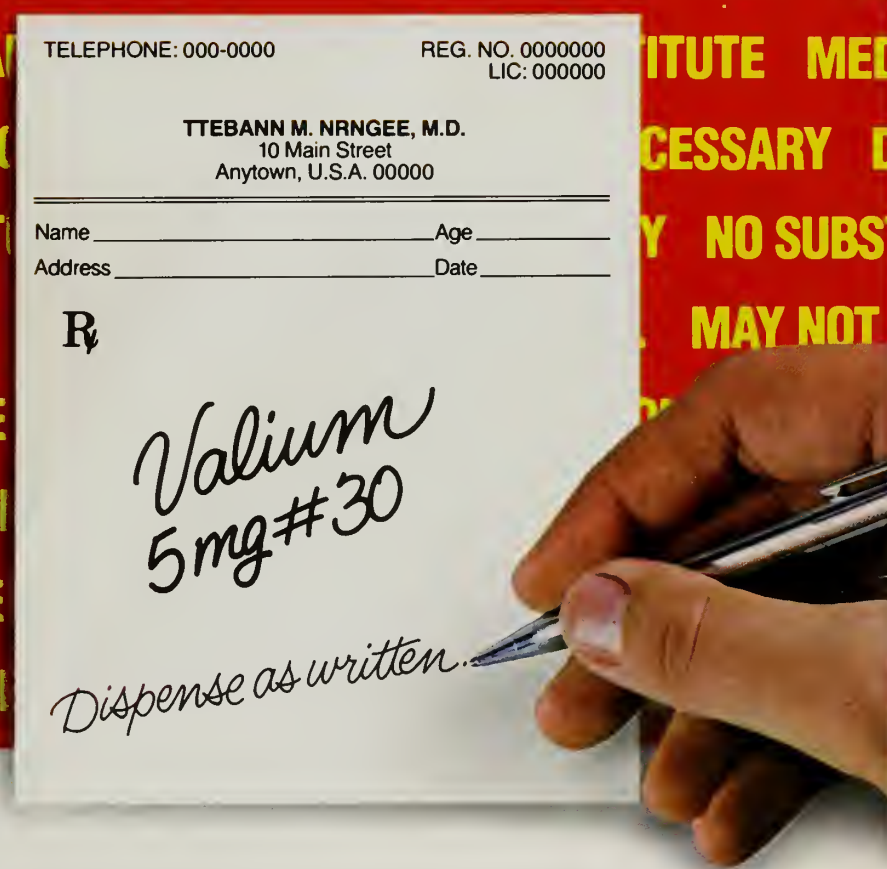

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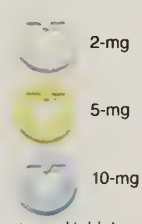

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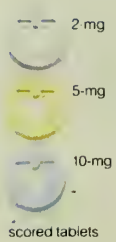

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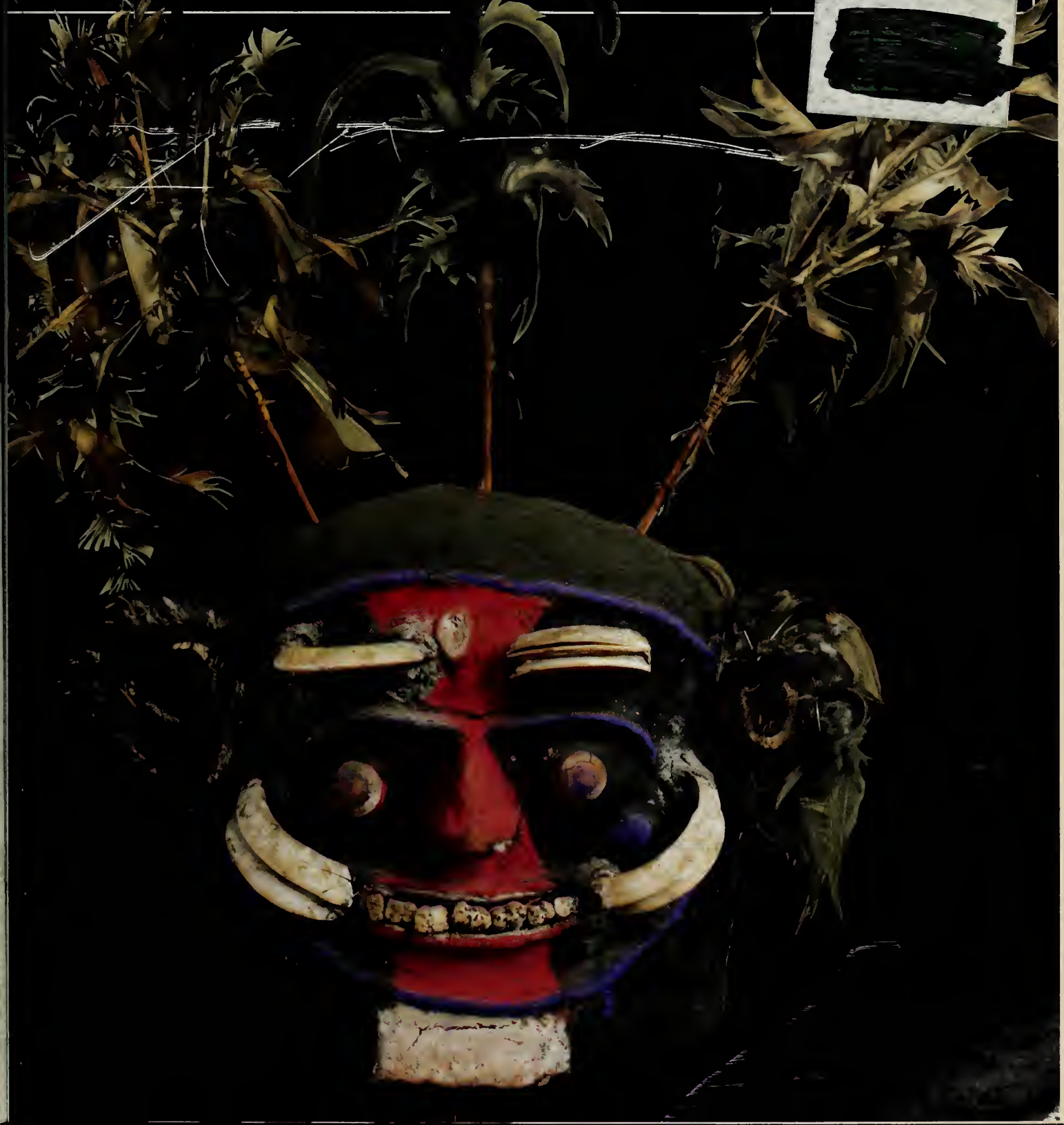
OHIO Medicine

JOURNAL OF THE OHIO STATE MEDICAL ASSOCIATION

VOL. 85, NO. 9 SEPTEMBER 1989



In the depressed and anxious patient

See Improvement

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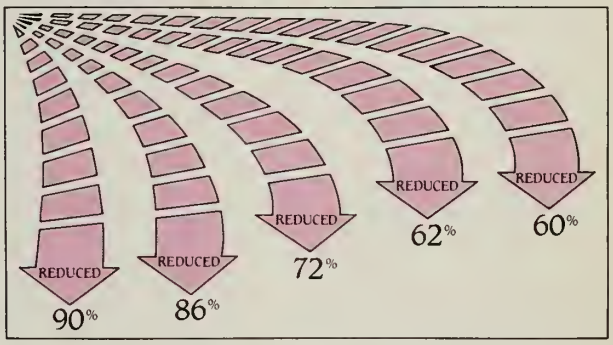
In The First Week[1]...
And The Weeks That Follow

- 74% of patients experienced improved sleep after the first *h.s.* dose[1]
- First week reduction in somatic symptoms[1]

Percentage of Reduction in Individual Somatic Symptoms During First Week of Limbitrol Therapy*



*Patients often presented with more than one somatic symptom.

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Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) (IV)

Limbitrol® DS

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) (IV)

Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

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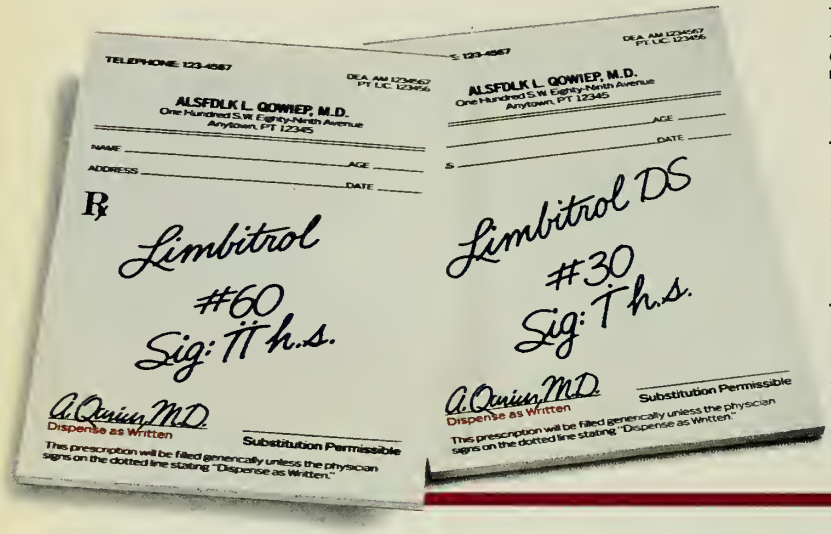
Please see summary of product information on following page.

In moderate depression and anxiety

- 74% of patients experienced improved sleep after the first *h.s.* dose[1]
- First week improvement in somatic symptoms[1]
- 50% greater improvement with Limbitrol in the first week than with amitriptyline alone[2]



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Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) Ⓥ

References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner JP, *et al: Psychopharmacology 61:*217-225, Mar 22, 1979.

Limbitrol® Ⓥ
Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

Usage in Pregnancy: **Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.**

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. *Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. *Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. *Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. *Endocrine:* Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

How Supplied: *Double strength (DS) Tablets,* white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets,* blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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Witch Doctors and AIDS

By Ralph Fried, MD

The Dayton Art Institute's "Oceanic Witch Doctor Headdress," shown on this month's cover of *OHIO Medicine,* is similar to the type of masks often worn by the "traditional healers" who serve the native populations of equatorial Africa. The mask is of interest not only for its primitive beauty, but because it adds to the mystic relationship between ill person and healer, a mysticism that also persists in the doctor-patient relationship in Western developed countries.

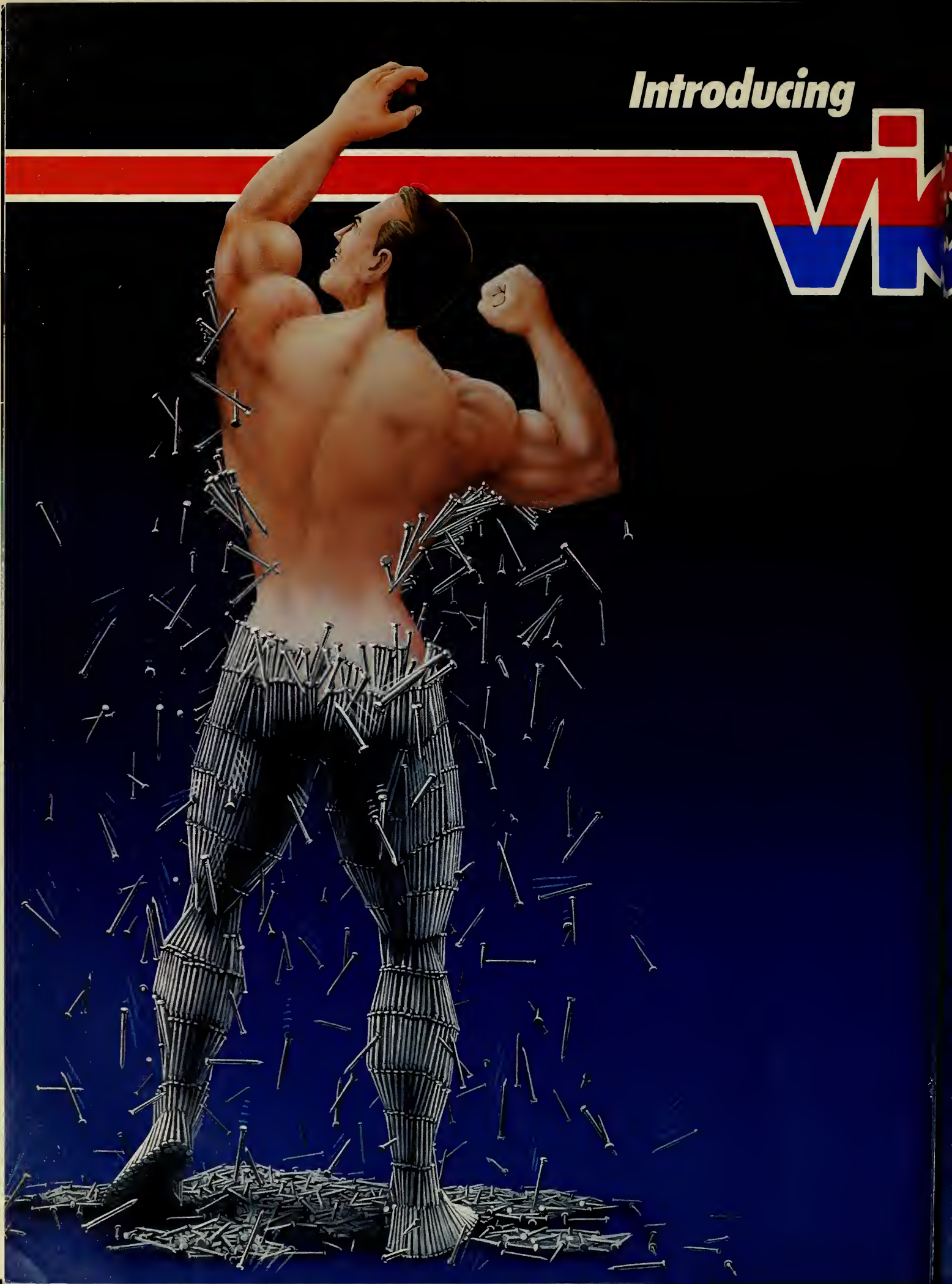
Case Western Reserve University in Cleveland and Makerere University of Kampala, Uganda, are engaged in a project grant, funded by the National Institutes of Health, to study AIDS in Uganda. Uganda, situated in East Africa, is a country rich in natural resources, but despoiled by political instability. A measure of political order has recently been restored to the country, however, and physicians from both CWRU and Makerere University are benefiting from the educational interchange. AIDS has reached epidemic proportions in Uganda where the principal means of transmission is heterosexual contact. Homosexuality and intravenous drug use are quite rare in that country. A matter of prime interest in the study is the vertical transmission of AIDS, or mother-to-child, since a similar problem has developed in our own country.

American physicians working in Uganda report that many patients still consult traditional healers.

American physicians who are working in Uganda report that many of their patients still consult the traditional healers, especially in rural areas where transportation is poor and roads to clinics are difficult to traverse. But even in the capital, Kampala, patients do seek health from folk doctors, whose armamentarium includes incantation, mysticism, herbs — and long conversations with the ill person. Western physicians acknowledge that these methods may be as efficient in treating this 20th-century scourge as is the pharmacopeia currently at their disposal.

Ralph Fried, MD, Cleveland, is a member of the OSMA Art and Culture Committee and a frequent contributor to **OHIO Medicine.**

The New Herbrides Headdress pictured here and on our cover is in the collection of the Dayton Art Institute.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1. Data on file, Knoll Pharmaceuticals
2. Standard industry new prescription audit. Data on file, Knoll Pharmaceuticals

Please see adjacent page for brief summary of prescribing information.

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(hydrocodone bitartrate 7.5mg [Warning May be habit forming] and acetaminophen 750 mg)

INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.

CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.

WARNINGS:

Allergic-Type Reactions: VICODIN/VICODIN ES Tablets contain sodium metabisulfite, a sulfite that may cause allergic-type reactions including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in certain susceptible people.

Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression.

Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

PRECAUTIONS:

Special Risk Patients: VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.

Cough Reflex: Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease.

Drug Interactions: Patients receiving other narcotic analgesics, antipsychotics, antianxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

Usage in Pregnancy:

Teratogenic Effects: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/ VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever.

Labor and Delivery: Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS:

The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include:

Central Nervous System: Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes.

Gastrointestinal System: The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation.

Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

Respiratory Depression: Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated.

DRUG ABUSE AND DEPENDENCE:

VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/ VICODIN ES Tablets should be prescribed and administered with caution.

OVERDOSAGE:

Acetaminophen Signs and Symptoms: In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.

Hydrocodone Signs and Symptoms: Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, (cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

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Published monthly under the direction of The Council for and by members of OHIO Medicine, 1500 Lake Shore Drive, Columbus, Ohio 43204-3824, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1989 Subscription: $25 per year.

Send address changes to: OHIO Medicine, 1500 Lake Shore Drive, Columbus, Ohio 43204-3824.

Second Class Postage paid at Columbus, Ohio and at additional mailing offices.

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ISSN 0892-2454
USPS 405-200

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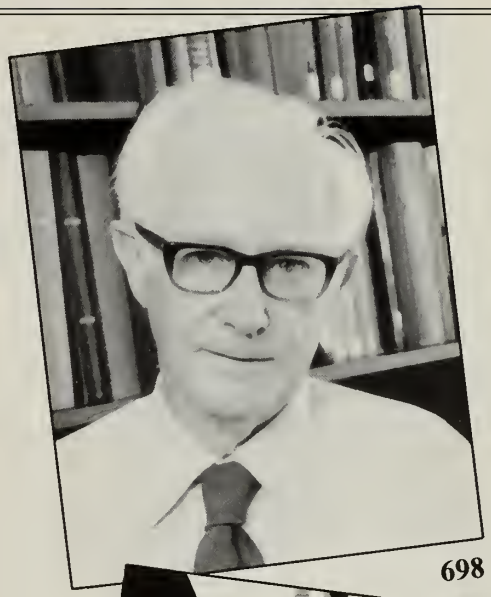
This month's cover illustrates a New Herbrides Headdress owned by the Dayton Art Institute. Photo courtesy of DAI.



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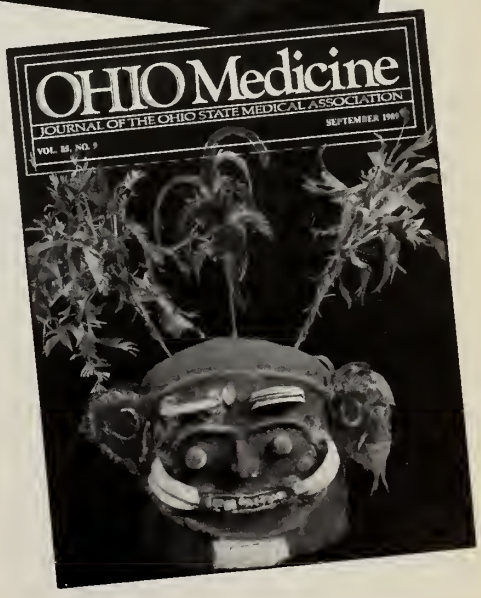

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OHIO Medicine Manuscript Guidelines

1. **EXCLUSIVE PUBLICATION.** Articles are accepted for publication with the understanding that they are contributed solely to this *Journal*. Permission for subsequent publication elsewhere must be obtained in writing from the Editor and from the Author.

2. **CORRESPONDENCE.** Address all correspondence relating to publication of scientific papers to: The Consulting Medical Editor, OHIO Medicine, 1500 Lake Shore Drive, Columbus, Ohio 43204-3824.

3. **MANUSCRIPTS.** (a). Manuscripts should be submitted *in the original* on standard 22 x 28-cm (8½ x 11-inch) white typing paper.

(b). A copy of the manuscript should be retained by the Author.

(c). *The entire text including lists of REFERENCES should be DOUBLE SPACED with margins of at least one inch on all sides.*

(d). Tables, charts, and figures (illustrations) should be submitted separately from that text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be by number, eg, (Fig. 1).

4. **ILLUSTRATIONS.** (a). Illustrations (photographs, drawings, graphs, and tables) should bear the figure number and author's name on back. When pertinent, the top of the photograph should be indicated. Do not clip or write on the back of the photos with a hard pencil, etc.

(b). The author should have written releases on all photographs in which patients can be identified.

5. **ABSTRACTS.** A *short* (100-word maximum) abstract should be included with the article. It should cover the main point so that the reader may readily obtain the gist of the article.

6. **SUMMARIES.** The summary should be a concise restatement of the information given in the body of the article.

7. **REFERENCES.** (a). Lists of references should be at a minimum to conserve space and expense and be limited to those essential to the subject and to which actual reference is made in the text. The Editor reserves the right to reduce the number when necessary.

(b). References should be listed in the *order of their appearance in the text.*

(c). Authenticity and accuracy are the responsibilities of the Author.

(d). Each journal reference should include in this order: Author's surname and initials, title of article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page number, and year.

"2. Doe J, Roe RX: How to go about it. Ohio State MJ 13:24-30, 1920"

Each textbook reference should include, in this order: Author's surname and initials, title of the book (capitalize all main words), edition, place of publication, name of the publisher, year of publication, volume, if more than one has been published, and page.

"5. Osler W: Modern Medicine, ed 3, Philadelphia, Lea & Febiger, 1927, vol 5, p 66."

8. **IDENTIFICATION OF PATIENTS.** Names, initials, hospital numbers, or any other identifiable labels, should *not* be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

9. **METRICATION.** All measurements must be in metric units. English units should be given in parentheses following the metric in all cases where the measurement was originally done in English units.

10. **EDITING OF MANUSCRIPT.** Following acceptance of a manuscript for publication, it will be copy edited in conformance with the editorial standards of the American Medical Association, which *The Journal* follows. The copy-edited manuscript will be returned to the Senior Author for approval. At that time, he is asked to make all corrections, sign the galley and return.

11. **CASE HISTORIES.** The *Journal* does not accept case histories.

12. **EDITORIAL ASSISTANCE.** Michelle Carlson, Assistant Editor, stands ready to assist the Author in preparing his manuscript. For his own assistance, however, the Author is encouraged to consult standard texts on medical writing, such as the *Style Book and Editorial Manual*, prepared by the Scientific Publications Division, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

FROM THE EDITOR

Developing the Vast Wasteland

Television has become such an institution in this country that, of course, it was just a matter of time before it infiltrated medical practice.

This month, Associate Editor Deborah Athy takes a look at the suddenly explosive field of medical videos and just how far television has come in its ability to educate. There are two sides to this medical video coin. On one side are the videos that demonstrate the newest developments and latest techniques available to you, the physician. No matter what your specialty might be, there more than likely is a video out there to educate, inform, update or instruct you. On the other side of this coin are the patient videos — those visual aids you use in your office (or loan to your patients) to teach them how, for example, to care for themselves after a heart attack; how to exercise; even what to expect during a surgical procedure. There are a variety of topics out there on both sides of this coin — and you won't want to miss reading about what you and your patients can learn from what was once referred to as America's "vast wasteland." Incidentally, a third angle to this topic are the health professionals who produce their own videos — whether those be patient-oriented films or informative tapes of a new, complicated technique for your colleagues. Those of you who might fit into this category may want to make note of the annual contest held each year for medical videos. Next year, maybe you should consider entering . . .

One subject that certainly seems to be appearing on medical videos frequently these days is laser medicine, a specialty that has evolved considerably since its infancy during the middle part of this century. Lasers are now being used in a number of surgical procedures, and Ohio physicians always seem to be right there on the cutting edge of this exciting field. Staff writer Michelle Carlson explores the latest developments in an area that still shows no sign of slowing its growth.

And speaking of growth . . . that has been the subject (in one form or another) of the Fels study of Yellow Springs, Ohio — which, at 60 years of age — is the "world's longest-running research study," besting Massachusetts' Framingham study by some 50 years. We couldn't resist taking a then-and-now look at this study — at one of its participants, its impressive collection of data and where it's headed in the *next* 60 years.

Finally, don't miss this month's "Ohio Medi-scene" section. You'll not only learn how to use your city or county health department more effectively, but you'll also discover how Ohio physicians (and OSMA members) will be tackling the profession's ethical problems.

Be watching for a chance to express your opinion of *OHIO Medicine*. The Journal Advisory Board is preparing, with staff, a "Readership Survey" which will help us better guide the contents of your monthly publication. We'll let you know all the details later.

Karen S. Edwards

Clochards, Penner or Rogues

By William J. Marshall, MD
President of the OSMA

In France they are called *clochards,* in Germany *penner,* and in America by many names — rogues, tramps, bums, hobos, or simply homeless people. Our traditional image is rags and bags; long, stringy, tangled hair; beards stained yellow with dirt; sunken cheeks; empty eyes; swollen legs and feet; poorly fitting and badly worn shoes. We see them scrounging rubbish here and there, stuffing it into the bulging pockets of their ill-fitting coats or into shopping bags. Our discard is their shopping center, the garbage cans the shelves from which they select and collect that on which they will exist.

It is difficult for most of us to visualize this kind of existence. There are those who have experienced this condition and then have written about it. George Orwell in 1933 in "Down and Out in Paris and London" wrote, "Still I can point to one or two things I have definitely learned by being hard up. I shall never again think that all tramps are drunken scoundrels, nor expect a beggar to be grateful when I give him a penny, nor be surprised if men out of work lack energy, nor subscribe to the Salvation Army, nor pawn my clothes, nor refuse a handbill, nor enjoy a meal at a smart restaurant. That is a beginning."

As a youngster growing up in a small town in mid-America, homelessness was an unappreciated condition. I know now that those people were there — transient, almost invisible, unwelcomed. I can still hear a voice say, "You, there! Move on! Move on!" Only one in this long line that has passed by each of us stands out in my mind. Often on Main Street I would see "Railroad Jack," a small, bearded, unkempt man in an oversized coat and railroad hat, walking slowly up the street, pausing every few steps to pull an imaginary chain to toot the whistle of an unseen train. My family told me he was a town character — harmless indeed and incompetent of mind. One day he simply disappeared. There was no official announcement of his death, no mourning, no graveside services. Perhaps there is only that haunting memory in my mind to mark "Railroad Jack's" invisible epitaph.

In the 1980s the homeless have increased in number and are forever visible. A tattered figure; unwashed hair; belongings carried in plastic bags secured with string, heavily weathered skin, swollen feet and legs; red tongues; cracked lips; an aimlessness; a sleeping body lying on a grate in the middle of one of our great cities. These are some of the obvious features that distinguish the homeless from ourselves and travelers.

How many? Politicians and media have claimed that three million Americans are homeless. A 1988 study by the Urban Institute concluded 600,000 are homeless. The truth probably lies somewhere inbetween, but all would agree it is far too many.

Who are they? One-third are mentally ill. Two-thirds have at least one serious personal problem: 35% are alcoholics; 20% are drug abusers; 24% have had a felony conviction or served time in a state or federal prison. They have been out of work on the average four years. Most homeless parents are black or Hispanic single women on welfare with little or no job experience, often driven from their homes by domestic violence.

Do we as a country have any answer to this complex problem? The private sector has mounted a phenomenal effort to help the homeless. In 1988, nine out of 10 shelters for the homeless were operated by community groups

and churches. Eighty thousand volunteers worked in shelters. The public sector paid about two-thirds of the shelters' operating costs in 1988, amounting to $1 billion. Shelters can offer at best short-term emergency care; i.e., hot meals and beds.

Are the medical needs of the homeless being adequately met? Fewer than one-third of the shelters provide treatment for mental illness and substance abuse. None offer adequate rehabilitative care. Very few offer child care or health care. Most of the homeless get no medical care at all, and when they do, it is in hospital emergency rooms only after the clinical condition has become dire.

". . . it became obvious to me that although medical care to this group was one of President Bush's 'thousand points of light,' we are not putting out enough wattage . . ."

As I looked at policies and goals for the homeless generically, it became obvious to me that although medical care for this group was one of President Bush's "thousand points of light," we simply are not putting out enough wattage. It was with this in mind that the OSMA Task Force on the Homeless was created. One of our goals should be to provide on-site medical care and mental health services on a volunteer basis. The Task Force had its initial meeting on July 13. Our army of students, residents, volunteer physicians and auxilians awaits its battle plans.

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AIR FORCE

OSMA-A FALL CONFLUENCE FRIDAY, OCTOBER 13, 1989

Co-sponsored by Wright State University School of Medicine, Dayton, Ohio

Barbara Marshall, President, OSMA-A

Are You a Member of The Sandwich Generation?

The Fall Confluence, scheduled for Friday, October 13, 1989, in Dayton, Ohio, on the campus of Wright State University, will kick off with a reception on Thursday evening, October 12, 1989. WSU's Contemporary Art Gallery is the perfect surrounding to set the tone for the contemporary subjects that will be discussed at Friday's Confluence.

"The Middle Years: The Sandwich Generation"

The middle years are the prime years of our lives. We are becoming more aware of ourselves and the opportunities and choices available to us. These choices will guide us through the remaining years of our lives. The middle years are a time for exhilaration and celebration, the marvelous midlife discovery of a whole new sense of self.

The Fall Confluence of the OSMA-A will focus on five exciting contemporary areas affecting our middle years. Through the co-sponsorship of WSUSOM we have been able to attract highly qualified speakers who are leaders in their respective fields.

Sherry Stanley, MD, a specialist in geriatrics, will set the tone of the conference by giving us a broad, demographic profile of who we are in the middle years.

Following the plenary session, two concurrent workshops will be offered. One is on the subject of body and mind. Judy Tangeman, MD, a geriatrician at the Dayton Veteran's Administration Hospital, will speak to us on how to balance our young desires and ideas with our aging bodies, or how to get our bodies to perform what our minds dictate.

The second concurrent morning workshop will focus on our new sense of self or our life after children. We will discuss the many opportunities and choices we have at this juncture of our lives. We are waiting for confirmation from the speaker.

A special treat awaits us following lunch. Ortho Pharmaceutical Corporation has agreed to send Donna Pepe, vice president of Marketing, as our guest speaker. Pepe will talk about the methods used by Ortho Pharmaceutical to market its products to women in the middle years.

Following the luncheon speaker, we will again have two concurrent workshops from which to choose. The middle years generation is the single largest group in our society. James Jacobs, PhD, professor and chair of the Department of Political Science at WSU, will challenge the participants with his presentation of specific political issues that affect us and how this age group will be the strong political force in the future.

Opposite the political workshop will be a very philosophical discussion on morality and the law: What is the law's claim on me? Robert D. Reece, PhD, professor and chair of the Department of Medicine in Society

continued on page 728

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The Forgotten Underserved

By Lance A. Talmage, MD

The state of Ohio has increased its physician population in the past several years. Many formerly underserved areas now have physicians, but one area remains *critically* underserved. The Army Reserve units in Ohio have only 40% of their needed physicians. Other Army areas in the country are up to 60%-70% filled. The pay, benefits and programs are no different in any of those areas. The United States military depends on the Reserve Forces for 70% of its medical assets. The surgical specialties are critically low since they are the mainstay of wartime care. The monthly medical activity of physical exams, preventive medicine advice and training of medical personnel are equally important and use all specialties.

I have heard many rationales for not joining the Reserve and National Guard but none justify the local apathy to our national needs. I would like to briefly address several of these objections.

Many physicians feel that if hostilities begin they can be drafted or volunteer to perform care they already provide. Most practitioners, however, are inexperienced in mass casualty situations and the time demands that preclude definitive care. The adaptation to resuscitation, debridement and secondary healing has required relearning in each past war. The draft or acquisition of volunteers cannot be instituted rapidly enough to provide trained physicians in the critical first days of conflict. The increased morbidity and mortality should be unacceptable to caring physicians.

Many formally underserved areas now have physicians but one area remains critically underserved . . . the Army Reserve.

Some feel that being part of the military implies approval of offensive war as a national policy. On the contrary, the Reserves are a cost-effective adjunct to our small active force which constitutes an effective deterrent to aggression. The stated mission of the Armed Forces is to "preserve the peace, not to promote war." A *strong* conventional force can in fact reduce the need for a nuclear alternative.

The time factor bothers many doctors but need not be a problem. The flexibility of the Reserve program allows many alternative activities to be substituted for weekend drills. A local group of physicians and nurses can train in their own hospital for pay and benefits. Yearly "summer camp" can be done year round at many centers

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around the country or in civil assistance actions in other areas of the world. Time is relative and a change of pace activity can be refreshing more than burdensome.

I am concerned that Ohio physicians are ignoring this patriotic duty. The military is committed to defend our country and its freedom — we as physicians should be committed to their medical care and welfare. Contact a local reservist if you have any interest or call me at (419) 471-4665, 471-2370.

Lance A. Talmage, MD, practices OB-GYN in Toledo.

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LETTERS TO THE EDITOR

Kudos to Dr. May

To the Editor:

As a former OSMA Accreditation Committee member, and currently alternate representative to the ACCME from the Association for Hospital Medical Education (AHME), I was gratified to read Part I of Dr. May's excellent article, "Developing and Maintaining Uniformity in the CME Site-Survey Process." This and the succeeding Part II will provide CME program directors and sponsors of CME activities with a thorough, well-articulated description of the accreditation process.

Through the ACCME Committee for Review and Recognition of the State Medical Societies as Accreditors of Intrastate CME Sponsors, a process is under way to achieve "reasonable uniformity" of the accreditation process among the state medical societies. Attention to these articles should enhance significantly current efforts to strengthen the accreditation process. This, in turn, will assist in bringing CME to its proper level of integrity in the continuum of medical education.

There remains the challenge and task of developing an appropriate CME credit system of comparable reliability and validity. This becomes increasingly urgent as *modern* CME methods and techniques, which actively involve physician participants, require demonstration of performance in addition to passive attendance.

Ohio physicians should experience a measure of assurance as a result of the accreditaton process currently implemented by the OSMA. Kudos to Dr. May and *OHIO Medicine* for a first-rate and timely focus on continuing medical education.

Howard S. Madigan, MD
Chairman, ACCME
Committee for Review
and Recognition
Sylvania

Outrageous decisions

To the Editor:

I would like for your readership to briefly consider the following illustrative (and actual) cases.

A 62-year-old, white female comes to medical care because of a large abdominal tumor. An ovarian carcinoma is debulked from her abdomen. Our government refuses her welfare claim because no sterilization permit was obtained!

An obese, black, hypertensive, diabetic female presents to the Emergency Room with chest pain and elevated enzymes. She is examined by three doctors who concur that she should be admitted to rule out a myocardial infarction. Six months after the fact, Blue Cross/Blue Shield decrees that this admission was unnecessary!

An elderly female presents with pain in the abdomen. I, as her family physician, believe she has appendicitis. Consultation is obtained with a board surgeon who believes she has appendicitis. A normal appendix was removed. Nationwide paid the board surgeon but refused to pay the assistant surgeon because the appendix was "not inflammed or ruptured!"

Is there any way that organized medicine can persuade the third-party payors to quit weasling out of their obligations and relate their determinations to medical reality? The above cited actual cases are so outlandish as to be beyond belief. What tool does organized medicine have to correct these inequities?

Jerome R. Sheets, MD
Portsmouth

Fifty-cent leeches

To the Editor:

The June article in *OHIO Medicine* on leeches in surgery ("Leeches 'catch on' in operating rooms," *OHIO Medicine* Vol. 85, No. 6, June 1989) struck a familiar memory note for me; of special interest was the endorsement of use by Tom Shaw, plastic surgeon at St. Vincent Charity Hospital in Cleveland, for I immediately recalled the use of leeches at Charity in the days of my residency there in 1933-35.

Leeches constituted the treatment of choice for thrombophlebitis in those days; they were spectacularly and quite swiftly effective in relieving pain, reducing edema and bringing about anticoagulation.

We used to purchase them for 50 cents each from Kurtz (?) drugstore on W. 25th Street. About two of them would do the job on a case. We called the effective anticoagulant hirudin

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Listed below are the OSMA Councilors and the districts they represent. If you have any questions or concerns regarding OSMA, please address them to your Councilor.

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after the generic name of the organism. Leeches, of course, were eventually replaced by heparin but in the days of Charity Hospital surgeons Weber, Dickenson, Herrick, Hallisy, Neary and Sheehan they were recognized as the best anticoagulant therapy then available. (Hard to beat the price too!) Tom Shaw's dad Darrel, I'm sure, would be quite familiar with their use.

It is always nice to read news from and about Charity and its staff, my first home and friends on my arrival from Dalhousie University Med School in Halifax, Nova Scotia. I am sending a copy of this note to Dr. Shaw.

John H. Budd, MD
Cleveland

Pursuing excellence

Editor's note: *The following letter arrived at OSMA headquarters, addressed to Dr. and Mrs. William Marshall. We thought it appropriate to run the letter here, so that donors to the AMA-ERF Fund might see how much their contribution is appreciated — and how it is used.*

Dear Dr. and Mrs. Marshall:

I would like to thank you for presenting us with the generous donation from the American Medical Association Education and Research Foundation. Each year, we try to use these funds to support important activities in our pursuit for excellence, as well as provide our students with financial assistance.

As we have done in the past, part of the funds will be used to support our Student Financial Assistance Program. This year, we are targeting a review of the curriculum as an important program. Funds from your donation will also be used to help plan and effect changes in the curriculum.

We would like to express a special thanks to the Ohio State Medical Association Auxiliary for their help in raising these funds. Their support is greatly appreciated.

Sincerely,
Joan E. Patton
Chief Fiscal Officer
College of Medicine and Office of Health Services
The Ohio State University
Columbus

Opportunities for retirees . . . are they out there?

To the Editor:

I read your article regarding retirement and how much retired doctors are in need in the rural communities. ("Retirees: The new recruits?", *OHIO Medicine,* Vol. 85, No. 4, April, 1989.)

I replied to a number of advertisements and inserted my own ads in *OHIO Medicine* for relocation. All I heard, however, is "You are too old to work." As for myself, I think I am too young to retire . . . any advice?

Sincerely,
John Lieu, MD
Columbus

Correction

The minutes of the Final Session of the House, which appeared in the July, 1989 issue of *OHIO Medicine,* incorrectly reported that Resolution 65-89, "Drunk Driving," was adopted as amended. In fact, the resolution was referred to Council. *OHIO Medicine* regrets the error and any confusion that may have been caused as a result.

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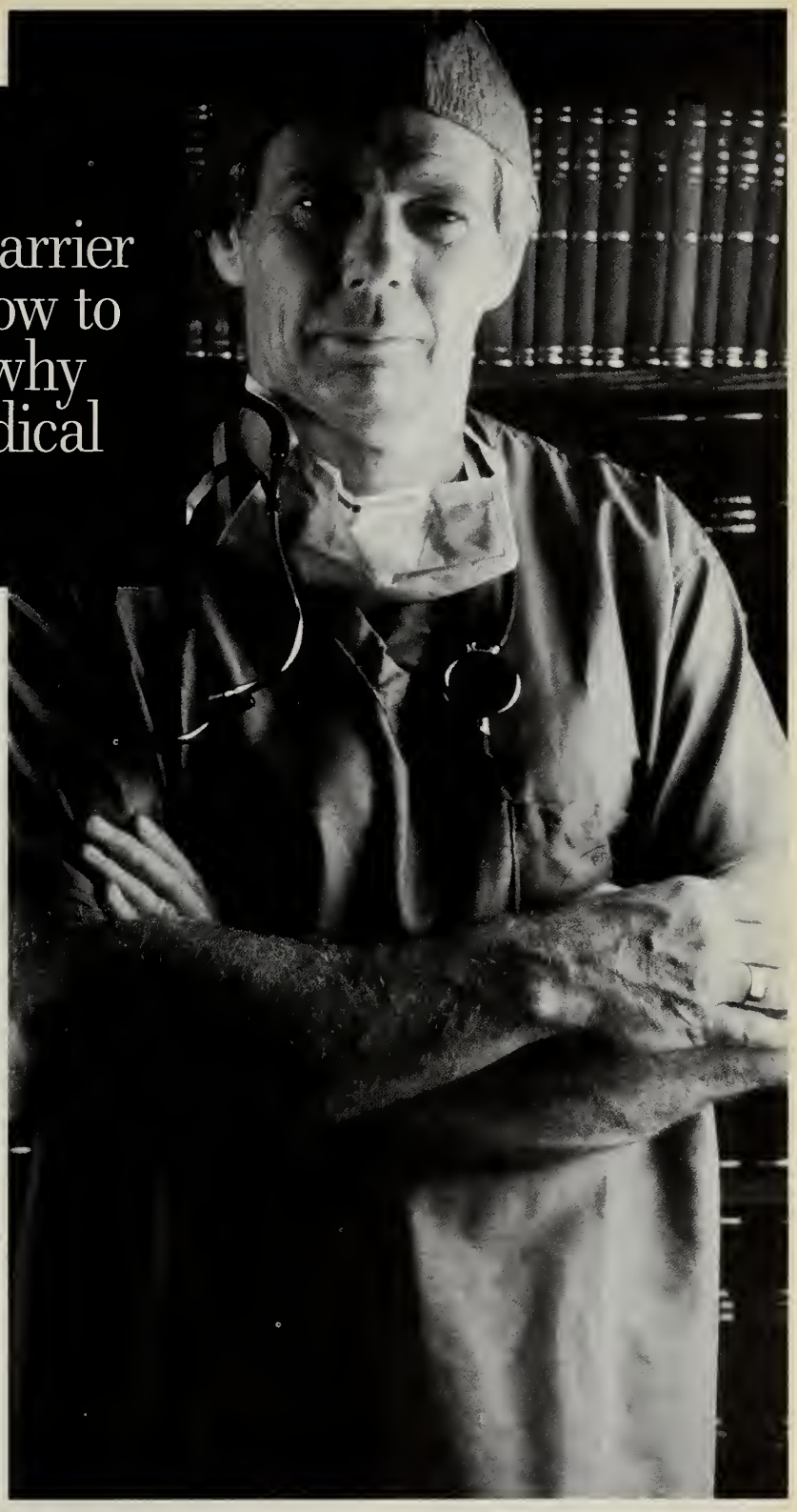

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OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians

Stress in the operating room

According to *Dorland's Medical Dictionary,* stress is "the sum of all nonspecific biological phenomena elicited by adverse external influences . . ." External influences that cause stress can include anything from traffic jams and long lines to health and money concerns.

But one's job can also be an external influence that elicits stress. According to the *Jobs Rated Almanac,* occupations in the U.S. with the highest stress include firefighters (first), race car drivers (second) and astronauts (third).

Among health-care professionals, surgeons were considered to have the most stressful occupation. Of all professions in the U.S., surgeons were ranked as the fourth most stressful.

Other occupations that made the stress list included NFL players, police officers, osteopaths, air traffic controllers, mayors, jockeys, public relations executives, photojournalists, advertising executives and NCAA basketball coaches.

Peer review judged effective

The majority of physicians answering an American Medical Association's survey have indicated they think their practices are reviewed effectively by their peers.

Of the 1,004 physicians interviewed by telephone, 63% gave peer review thumbs up, while slightly more than one quarter (28%) indicated they thought peer review is not effective.

Solo practitioners were more likely than group practitioners to reject peer review. And while most specialties were not significantly different from the national average of 63% who judged peer review effective, anesthesiologists, at 84%, had the highest acceptance rate.

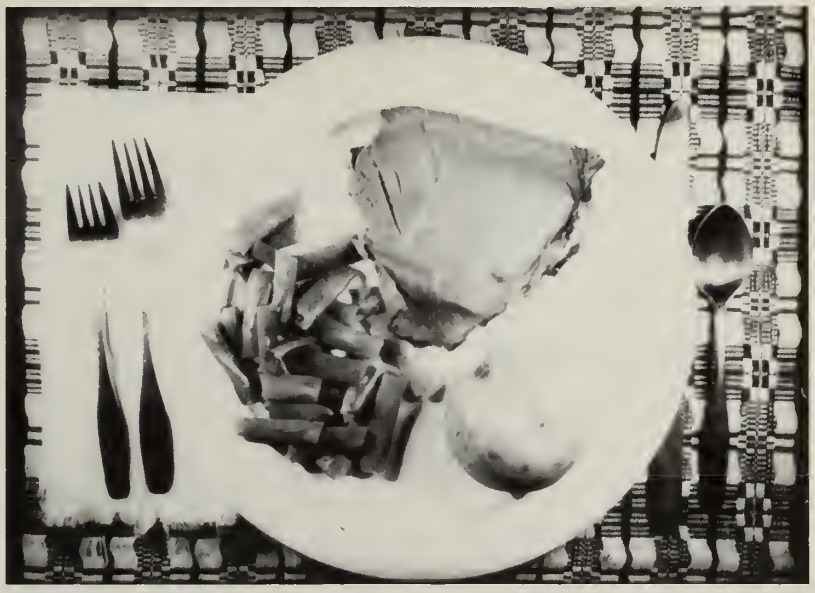
The survey also questioned whether or not physicians felt they had sufficient legal protection when acting as a peer reviewer, as opposed to being reviewed. A majority (61%) answered that they felt they had sufficient legal protection to participate in peer review activities, one-fourth said they did not have sufficient legal protection and 15% were unsure.

Rx: Food . . .

In Texas, family physicians are whipping out prescription pads and prescribing food for patients who are chronically undernourished or hungry.

The innovative Texas Academy's "Food by Prescription Program" provides physicians with a resource list of hunger assistance programs available throughout the state.

Once the physician locates an appropriate program for the patient, he or she writes the program's phone number on a "prescription" blank and hands it to the patient, encouraging the patient to give the service or program a call.



"Some of us see the hunger in our practices every day, but we didn't know where to refer these patients," says J.J. Gaspard, chairman of the Texas Academy's Minority Health Committee which developed Food by Prescription, in an issue of the AAFP *Reporter.*

More than four million requests for food assistance were made to Texas food pantries, soup kitchens and other emergency food providers in 1986.

Cleveland's Alzheimer Research Center deemed excellent

The Alzheimer Center of the University Hospitals of Cleveland had been recently designated one of only 12 national research centers of excellence by the National Institute on Aging.

The NIA designation brings with it a $5 million, five-year grant that will be used to further expand the center's research.

UHC's Alzheimer Center is the country's only Alzheimer's disease research program funded by both NIA and the National Institute of Mental Health. Affiliated with Case Western Reserve University School of Medicine, it is Ohio's first and only state- and federally-designated Alzheimer's disease research center.

Smoking and fat distribution

Here's some news to tell your patients who are reluctant to give up smoking for fear of gaining weight: Smoking may be hazardous to your waistline.

Smoking might help people to stave off a few pounds, but it may also lead to a distribution of body fat that is associated with an increased risk of heart disease, diabetes and early mortality, according to a National Institute on Aging study reported in *JAMA* (February 24, 1989).

"Cigarette smokers as a group weigh less for their height than non-smokers, and cessation of smoking leads to significant weight gain," the study confirms. But when researchers examined the ratio between waist and hip circumference, smokers were found to have significantly larger waist-hip ratios (WHRs) than non-smokers.

In addition, the study found there is a graded dose-response between the number of cigarettes smoked and the WHR.

The study researchers reported that fat distribution patterns with high WHRs are associated with risk factors such as abnormal serum lipid levels, hypertension and glucose intolerance, which have been linked to increased mortality.

So while it's true that individuals in the study tended to put on a few pounds after they've kicked the habit, their WHR did not increase significantly and was only one-fifth the expected increase for the weight they gained, the article continued.

"These paradoxical changes in WHR suggest that there are harmful effects of cigarette smoking on the pattern of distribution of body fat," the researchers concluded. "These facts introduce still another reason to suggest that the decision to initiate or to continue smoking to control body weight is unwise."

Current AIDS statistics

According to the Ohio Department of Health, a total of 1,353 cases of acquired immunodeficiency syndrome have been confirmed in the state (130 new cases were diagnosed in the first half of this year).

White males in the 30-39 age group continue to be the predominant victims of the syndrome, and homosexual contact remains the principle means of transmission (68%). Ohio has had 763 fatalities while the United States as a whole reports 54,402 AIDS-related deaths.

Presently, Ohio ranks 13th in states with AIDS victims. Overall, 94,280 cases of AIDS have been reported in the U.S. to date.

Health care for the poor supported

Physicians, in answering a survey by the American Medical Association, have overwhelmingly shown support for federal funding of health care for the poor.

Of the 1,004 physicians questioned, 72% answered "Yes" to the question, "If it meant that taxes would be increased, would you support . . . an increase in government spending to ensure that all people below the poverty line would have access to medical care?"

Meanwhile, 21% indicated they would oppose such a plan, and 4% said it would depend upon the specifics.

Interestingly, when the AMA polled 1,500 Americans age 18 and older, 73% — or just 1% more than physicians — said they would support such a plan, with 51% of those indicating strong support.

Some injuries unavoidable

Team physicians may want to keep an eye on their young athletes during the second half of a game, suggests a report from the National Athletic Trainers' Association (NATA) — that's when injuries are more likely to occur.

The association, which monitored high school sports injuries for the past two years, reports that 60% of injuries in high school basketball games occur during the second half, while 63% of women injure themselves in the second half of a game.

Fatigue may be blamed in some instances, says NATA Research Director John W. Powell, PhD, who cites statistics that show "35% of boys' injuries were in the fourth quarter compared to 10% in the first period." (Girl athletes showed a similar tendency.)

Unfortunately, the report says that most injuries occur during practice — when a physician isn't present. Powell suggests the reason is that most teams practice more than they play, and that more athletes participate.

Ohio MDs increase reports to Medical Board

Ohio doctors may be more apt to report physicians who violate the Medical Malpractice Act than they have been in the past, according to a recent article in the *Dayton Daily News*. The controversy surrounding Dayton physician James Burt, MD may have struck a chord in Ohio physicians that even a 1987 law calling for a $1,000 fine against non-complying doctors couldn't evoke.

According to Medical Board spokesperson Lauren Lubow, the Medical Board received only one physician complaint in 1987 and the first nine months of 1988.

In November 1988, the Board announced that some Dayton-area physicians may have allowed Burt's controversial surgery to go unchecked. After that time — from the end of 1988 through June 1989 — Lubow reported that the Board received nine complaints.

While the connection between the Burt case and the increase in physician reports seems plausible, Lubow says the Medical Board cannot say with certainty what prompted the increase in physician reporting.

COLLEAGUES

ROBERT BURT, MD, Loveland, and **LUIS QUIROGA, MD,** and **ELMER WAHL, MD,** both of Cincinnati, have received awards of distinction for contributing to the medical education of University of Cincinnati medical students . . . **EVELYN HESS, MD,** Cincinnati, is one of 20 Ohioans to receive a 1989 Director's Service Award from the Ohio Department of Health for her volunteer service related to AIDS . . . **ROBERT LIEBELT, MD,** Akron, has received the Doug Dieken Award for Courage which each year honors a Summit County physician who displays courage and commitment to the betterment of people's mental health . . . **SANFORD SUMMERS, MD,** Willoughby, has been named chief of the Adult Addictive Disease and Adult Dual Prognosis Programs at Laurelwood Hospital . . . **LESTER W. MARTIN, MD,** Cincinnati, has received the Citation of Merit from the Medical Alumni Organization of the University of Missouri-Columbia, the organization's highest honor . . . **DENNIS D. BARBER, MD,** Beavercreek, was awarded the Wright State University Academy of Medicine's Outstanding Achievement in Medical Education and Research Award . . . **JOSEPH LEVINSON, MD,** Cincinnati, has received the American College of Rheumatology's Distinguished Rheumatologist Award . . . **RANDOLPH GIBBS, MD,** Fostoria, has been named medical director at Good Shepherd Home . . . **WILLIAM C. MILLER, MD,** Cincinnati, has been elected president of the medical staff at Our Lady of Mercy Hospital . . . **WILMA BERGFELD, MD,** Cleveland, is one of 10 women recognized by the YWCA for outstanding professional contributions . . . **NORTON J. GREENBERGER, MD,** Cleveland, has received the 1989 Distinguished Alumnus Award from Case Western Reserve School of Medicine . . . **WARREN W. DAUDISTEL, MD,** Fairfield, has been appointed medical director at Schroder Manor Retirement Community . . . **MARTY FUJIMURA, MD,** has been named medical director for HealthPark, Good Samaritan Hospital's medical specialty facility . . . **PAUL R. GUTHEIL, DO,** Galloway, has been elected chair of the Advisory Board of the Ohio University College of Osteopathic Medicine . . . **STEVEN B. WERTHEIM, MD,** Cleveland, was one of 20 physicians to accompany the American team to the 13th World Maccabiah Games in Israel in July . . . **KEITH KRABILL, MD,** Canton, has received the William H. Falor Research Award, named after the Akron City Hospital physician and researcher . . . **JAMES A. BLOCK, MD,** Cleveland, president of University Hospitals, has received the Hadassah Medical Organization's Distinguished Service Award . . . **DOUGLAS L. MELHORN, MD,** Ann Arbor, has been named medical director of the emergency department and ambulatory services at Marietta Memorial Hospital . . . The Academy of Medicine of Cleveland gave several awards to its members recently: **KARL S. ALFRED, MD,** Cleveland, Special Honors Award; **DONAVIN BAUMGARTNER, JR., MD,** and **HENRY G. KRUEGER, MD,** both of Cleveland, Distinguished Service Awards; **HELMUT M. DEHN, MD,** Clinician of the Year; and **FREDERICK T. SUPPES, MD,** Gates Mills, Distinguished Membership Award . . . **RAY GIFFORD, MD,** and **RALPH A. STRAFFON, MD,** both of Cleveland, have received the National Health Professional of the Year Award. Dr. Gifford has also been honored with the 1989 National High Blood Pressure Education Program Award for Individual Achievement . . . **BAHMAN GUYURON, MD,** Lyndhurst, has received the Greater Cleveland Health Professional of the Year Award . . . **HELEN GLUECK, MD,** and **LUCY O. OXLEY, MD,** both of Cincinnati, are two of eight women named as the YWCA's Women of Achievement . . . **TENNYSON WILLIAMS, MD,** Dublin, has been named Ohio's Family Practice Educator of the Year . . . **EMMETT MONROE, MD,** Cuyahoga Falls, has been named Family Physician of the Year by the Ohio Academy of Family Physicians . . . The Hospital Cancer Program has named the following physicians cancer liaison physicians: **DALE COWAN, MD,** Parma, Parma Community Hospital; **JOSEPH B. CARTER, MD,** Euclid, Euclid General Hospital; **RICHARD SCHLANGER, MD,** Dublin, St. Anthony Medical Center; **LAWRENCE LANGSAM, MD,** Cleveland, Meridia Huron Hospital; **ORLANDO R. CASTRO, MD,** East Liverpool, East Liverpool City Hospital; **KENNETH A. SPANO, MD,** Euclid, Meridia Euclid Hospital; **JAMES W. WIGGIN, MD,** Mansfield, Mansfield General Hospital; **JOHN DORSKY, MD,** Shaker Heights, Lake Hospital System; and **DAVID J. DUNCH, MD,** Youngstown, St. Elizabeth Hospital and Medical Center . . . **THOMAS E. FOX, MD,** Mason, has been re-elected president of the American Heart Association.

THE LOWER RESPIRATORY TRACT—
More vulnerable to infection in smokers and older adults

Experience counts

Ceclor® Pulvules® 250 mg
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think of it first

For respiratory tract infections due to susceptible strains of indicated organisms.

Summary.
Consult the package literature for prescribing information.

Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β-hemolytic streptococci).
Contraindication: Known allergy to cephalosporins
Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.
Administer cautiously to allergic patients.
Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.
Precautions:
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)
Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology
- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis, elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly). [061088L]

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OHIO MEDI-SCENE

OSMA's new ethical decision-makers . . . local health departments: a best-kept secret? . . . improving the health of Ohio's workforce . . . winners of the OSMGA tourney . . .

OSMA's new ethical decision-makers

If the thickness of the information packets distributed to members of OSMA's Judicial and Professional Relations Committee at its meeting this past June is any clue, the field of medical ethics is growing more and more complex each day.

That's precisely why OSMA President William J. Marshall, MD, charged the committee with its new task of examining ethical issues, shortly after he assumed office in May.

"I feel it is timely for the OSMA to begin to explore (the subject of medical ethics) proactively," he wrote in his "Presidential Perspectives" column in the July issue of *OHIO Medicine*. "I would hope the committee will briefly review all ethical issues, but maintain a focus on those drawing attention in our state. We need to exhibit ethical activism in the areas of self-referral, joint-venturing, utilization of limited resources, relationships with industry and identifying impaired or unethical physicians. This list," he continued, "is not meant to be confining or all inclusive."

Nor is it. In fact, if anything, the list serves as catalyst, forcing other ethical issues out into the open.

In many respects, the OSMA's Judicial and Professional Relations Committee is the AMA's Council on Judicial and Ethical Affairs,

OSMA Deputy Director D. Brent Mulgrew (left), Chairman William H. Kose, MD (center) and the AMA's Edward B. Hershfeld field questions from committee members.

The newly reactivated Judicial and Professional Relations Committee (right) will help guide the OSMA through today's tough ethical issues.

OSMA's new ethical decision-makers . . . *continued*

with a stateside spin. Like its national counterpart, it will offer position statements and guidelines on today's toughest issues to OSMA members, but like its national counterpart, it too will take care to write these policy papers in chalk. Rarely in the field of ethics, one learns, is anything carved in stone.

There are certain guidelines that should be in place, however, to safeguard rights and to steer consciences, if nothing else, and that will be this committee's job.

"We are attempting this year to elevate the profession," says Dr. Marshall. "The days of taking a reactive, rather than proactive, stance in medicine are over. This is your role," he told the committee in June. "You'll have to make some hard decisions in the year ahead, but that's what your job is all about."

To give you a better idea of the scope of issues coming before the committee's attention, here are some of the topics they addressed in June:

- **Grievance and disciplinary hearings**

The committee listened to the remarks of Edward B. Hershfeld, JD, associate general counsel, health law, at the American Medical Association, and OSMA's outside legal counsel, William Todd, JD, of Porter, Wright, Morris and Arthur law firm, Columbus. Both attorneys pointed out that while legal counsel may be available to physicians at grievance or investigatory review, they are sometimes unnecessary.

"But don't object if the physician wants one there," Hershfeld says. "The ability to have an attorney present lets people feel their safeguards are being protected."

At the disciplinary hearing, however, attorneys should not only be present for the defendant, but for the hospital, a medical society or whatever body is bringing charges.

"It assures a fair process for everyone," says Todd.

A little-known fact, perhaps, is that county society disciplinary measures can be appealed to the OSMA.

"In the 15 years I've been with the association, only two appeals have been brought to the OSMA's attention," says Brent Mulgrew, the association's deputy executive director. The county's decision is stayed during review on process — to decide whether or not due process has been accorded the physician, says Mulgrew. A redetermination of the facts considered by the county is not made.

Yet another offshoot of this discussion, and one that will no doubt reach the committee's attention at some point in the future, is the federal data bank which, when finally up and running, will provide information to hospitals and medical societies checking credentials of potential members/staff — but which also threatens to focus a "Big Brother" aura onto the medical profession.

"The information that will go into this bank is going to stay with this practitioner forever," cautions Todd. "It raises the stakes in the game."

In fact, the possibility of a professional career that's haunted by the spectre of whatever is available through the federal data bank is going to give some physicians the added incentive to contest denied memberships and staff privileges, grievance and disciplinary hearings, "because it's a brush that will tar them forever," says Todd.

> ***"The information (going) into this bank will raise the stakes in the game."***

While some committee members then expressed concern about the "boomerang effect" an increasingly tighter ethical policing role by the medical society may have on the rank-and-file physicians, other members worried about publicly aired complaints if state and county medical societies don't step in to police its members.

"There is no impenetrable shield," says Mulgrew. "Non-medical people in our society believe that we don't police ourselves. Until they do believe it, we have failed to meet their expectations, and if we fail there, the public will demand the government expand its activities in the ethical realm."

• **Physician referrals**

The so-called "safe harbors" for physician investments established by rule after the enactment of anti-kickback laws in the last Medicare revisions is a hot subject right now in the popular press, and threatens to be an even greater issue in the future.

This committee will consider either preparing a position statement or providing information to physicians on the subject of investments and conflicts of interest after the AMA Council releases its report this fall.

No matter what federal legislation may eventually evolve on this subject the committee can still help to determine the ethical issues for Ohio physicians.

• **Medical records**

Who should medical records be released to? Should a fee be charged for the transfer of medical records, and if so, what is a reasonable fee?

Committee Chairman William H. Kose, MD, Findlay, would like to see the committee expand the existing ethical rules for the transfer of medical records and the setting of fees, as well as what to do with medical records following the death of the physician. Staff will prepare a discussion document for the committee's review.

• **State Medical Board**

Because of a lack of time and staff, the State Medical Board has not focused on considering ethical violation charges, ranking such cases low on its list of priorities. The Board's increased budget and the upcoming data bank of violations, put in place by the Health-Care Quality Improvement Act, may change that, however.

The committee and OSMA Council may soon start working with the Board to see how best to report these ethical violations and how to motivate the Board to act upon them.

• **Other issues**

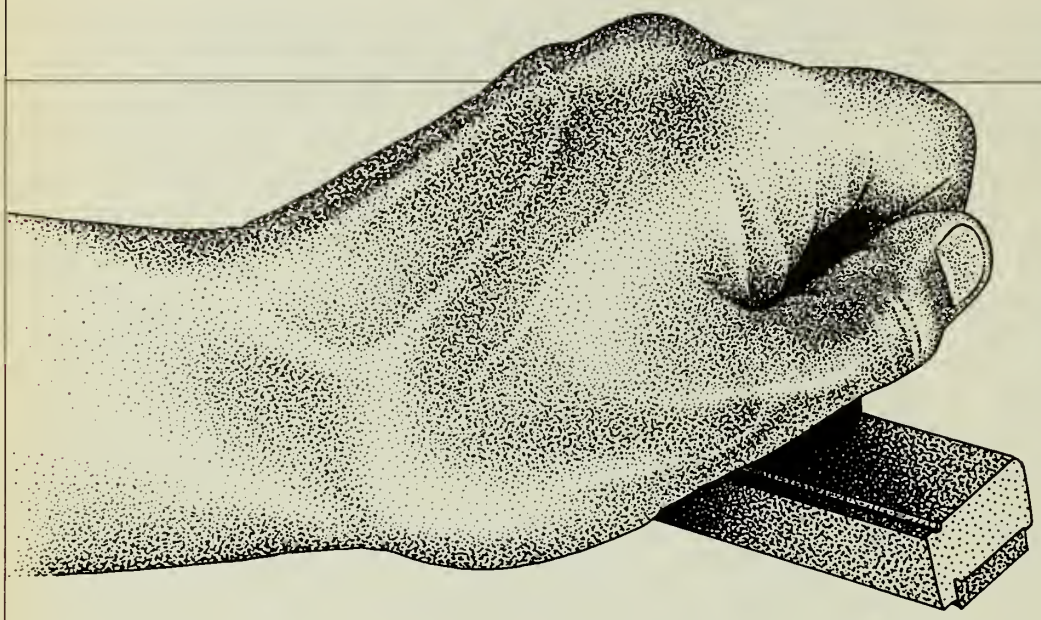
Termination of life support, industrial marketing and the effect of PROs on the practice of medicine are other issues that may be brought to the committee's attention.

While the AMA's Council on Ethical and Judicial Affairs continues to struggle with these issues on a national level, the newly energized OSMA Committee on Judicial and Professional Relations will help this state's physicians decide what is ethical . . . especially regarding those issues that are currently raising such a loud public outcry. — *Karen S. Edwards*

Members of OSMA's Committee on Judicial and Professional Relations

William H. Kose, MD, Findlay, Chairman
Alcuin D. Bennett, MD, Toledo
William Bernie, MD, Dayton
G. William Bretz, MD, Dayton
Robert N. Downer, MD, Dayton
Pura G. Garin-Vargas, MD, Norwalk
David H. Levy, MD, Youngstown
Herbert D. Long, MD, Cincinnati
Marvin S. Platt, MD, Akron
John H. Sanders, MD, Cleveland
Robert K., Seidel, MD, Akron
Jerome R. Sheets, MD, Portsmouth
Lance A. Talmage, MD, Toledo
J.J. Trevino, MD, Vandalia
Manuel Tzagournis, MD, Columbus
Daniel W. van Heeckeren, MD, Cleveland
S. Marcus Wigser, MD, Cincinnati
R. Donald Woodson, MD, Maumee
Donald Zimmerman, MD, Massillon
Robert M. Zollinger, Jr., MD, Cleveland

OHIO MEDI-SCENE



TOP SECRET

Local health departments: the medical community's best-kept secret?

They're out there (though you may not know just where) . . . working hard (at what, you're not quite sure).

Strangely enough, local health departments (either city or county) are probably the best-kept secret in the medical community.

C. William Keck, MD, who has served as director of the Akron City Health Department in Summit County since 1976, offers an explanation:

"I think a lot of physicians don't understand or they misunderstand what it is we do," he says.

Dr. Keck turns to a recent Institute of Medicine and Health report on the Future of Public Health for an official definition.

"Three responsibilities (of public health) are outlined," he says.

The first is assessment of need, through data collected. The second is policy development, using the assessments that were made to develop programs to benefit the community; and three, assurance, or ensuring that the people who need these services receive them.

In a nutshell, then, what local health departments do is try to meet the primary health-care needs of their community — and if that function is a deep, dark secret to physicians, it's by no means a secret to the thousands of Medicaid, underinsured and uninsured patients who comprise most health departments' patient base.

"We're the court of last resort for many medically underserved individuals. We do our best to plug up the holes that exist in the present health-care system," says Dr. Keck.

And holes there are.

Maurice Mullet, MD, director of the Holmes County Health Department for the past 15 years, and current president of the Holmes County Medical Society, points to some physicians' setting of quotas for Medicaid patients as the reason for some of these holes.

"Once the quota has been reached, the physician won't see any more Medicaid patients, so we get them," he explains. "I recognize the economics of running a practice might prompt this decision, but I'm old-fashioned enough to think that the profession has a responsibility to

see to it that everyone in the community who needs medical care receives it — even if there is no compensation for delivering the care."

"Physicians sometimes forget what's important," agrees Dr. Keck. "They focus on the individual, as they have been trained to do — and that's a worthwhile goal — but they also need to realize that community health is integral to the well-being of the individual."

Dr. Mullet says he would feel much more comfortable with quota-setting, for example, if those physicians who set quotas could help out in health department clinics, where traditionally help is always needed.

And, Dr. Mullet is quick to point to one of his own clinics where local family practitioners *did* recently rally to support a suddenly floundering prenatal clinic.

"The individual who was providing most of the care for this clinic left obstetrical practice. All of the family practitioners who practiced OB at the hospital took turns serving in the clinic until an arrangement could be made for one physician to do the job, with the rest providing coverage."

That's the kind of support both Dr. Keck and Dr. Mullet say the local health departments need from their respective medical communities.

It's not the only kind of support, however. Reporting communicable diseases is another.

Several years ago, the OSMA did a study on communicable disease reporting and learned that only 10%-20% of this required reporting was being done, says Dr. Mullet.

Those who *do* report aren't always as prompt as they should be — yet timely reporting is essential if serious outbreaks of measles, hepatitis, even AIDS, are to be contained, both health directors agree.

"The health department can set up special immunization clinics to prevent a serious outbreak — but we need to know an outbreak has occurred," says Dr. Mullet.

Again, both directors say that lack of knowledge may explain why more reporting isn't being done.

"Medical students don't get enough exposure to public health while they're in medical school," says Dr. Mullet.

Dr. Keck, however, is in a situation where medical students (from the Northeastern Ohio Universities College of Medicine) rotate routinely through its department — but, he admits, the Akron Health Department is more academically involved than are most local health departments.

"NEOUCOM took part in recruiting for this position," he explains. "In fact, that's what attracted me here."

Clinics and communicable disease reporting are, of course, only a small portion of a health department's functions. Meeting the health-care needs of a community involves much more.

"Here in Akron, we manage over 50 programs — shall I list them for you?" he asks.

For those who may not know, local health departments can perform any or all of the following functions, depending on community size, need and budget:

- enforce the Federal Clean Air Act
- handle environmental issues (food protection, nuisances, drinking water, waste water, swimming pools, etc.)
- handle birth and death data and communicable disease reports
- offer health education on lifestyle-related issues
- handle housing issues (i.e. ensure that older, existing homes meet a certain code of safety and that their appearance maintain the character of the neighborhood)
- maintain laboratory services
- offer alcohol and drug prevention and treatment programs
- provide sexually transmitted disease prevention and treatment programs
- provide anonymous testing and counseling sites for AIDS and provide support services for AIDS patients and their families
- mosquito control
- enforce right-to-know laws (workers and the community are informed about the hazardous material with which they may come in contact)

There are more, but again the number of types of services will depend from locale to locale, and to a lesser extent, on economic environment.

"During the late '70s, Akron was hit pretty hard by an economic slowdown," Dr. Keck says. "We lost 40% of our staff over an 18-month period."

Consequently, programs had to be dropped.

"We entrenched ourselves in those areas that have been traditionally done, or which would, politically, be difficult for us to stop doing," Dr. Keck continues. "But in situations like that, creativity suffers."

Programs, such as chronic disease control and education on

"Physicians sometimes forget what's important . . . they need to realize that community health is integral to the well-being of the individual."

OHIO MEDI-SCENE

Local health departments: best-kept secret? . . . *continued*

lowering cholesterol levels, were added as the health department built its budget and manpower reserve.

"That's where the local medical societies can be helpful," says Dr. Keck, who has also served as president of the Summit County Medical Society.

The Summit County society, in fact, was instrumental in getting a stop-smoking campaign off the ground (see "Summit County's Smokeout" in the "County Collection" section of *OHIO Medicine,* April, '89).

"Physicians and organized medicine need to look for public health problems that they can solve," says Dr. Keck. "But the monkey is also on the back of local health departments. They need to let the medical community know what their problems are — and how physicians can help."

They may also need to educate the physician more thoroughly about the jobs they perform, the clinical services that are available, and the resources they can offer physicians.

"With regard to AIDS testing, for example, physicians need to understand the subtleties of testing," says Dr. Keck. "We can offer not only expertise in this area, but also help in dealing with patients and their families. They (physicians) *should* refer AIDS patients to us."

But how many physicians are aware that there is a local health department out there, ready and able, to assist in these matters?

"Too often, health departments are at war with local physicians, for a number of different reasons," says Dr. Keck.

Dr. Mullet also believes a barrier between physicians and health departments exists, though he doesn't believe it's antagonistic in nature.

"It goes back to that lack of knowledge," he says.

"But physicians *should* know more about their public health departments, and be either supportive of them or constructively critical," adds Dr. Keck.

To learn more about your local board of health, Dr. Keck recommends becoming actively involved — either by serving on it or by involving yourself in public health issues through your hospital or county medical society.

"Physicians can also help local health departments in a number of ways — just by remembering the responsibility they have to the community," says Dr. Keck.

"Care for the medically underserved has to be shared," he emphasizes. "There is no other place to go. We are still far from meeting the needs of this population. There is a lot of rhetoric going on right now in Washington about this issue, but while the rhetoric continues, we have to struggle along in the trenches. A lot of physicians are already doing their share — but those who aren't need to realize we need their help." — *Karen S. Edwards*

Improving the health of Ohio's workforce

The Ohio Department of Health is hoping to improve the quality of health for Ohio's workforce, but they need your help to accomplish their mission.

Physicians must report occupational diseases to the ODH, pursuant to Section 3701.25 of the Ohio Revised Code. All reports are handled in a confidential manner.

Because the knowledge of work-related health problems in Ohio is severely limited, reports the ODH, surveillance, based on physician reports, is important in order to estimate the prevalence of occupational disease in Ohio and to effectively direct control measures where they are needed. It also allows the ODH to assess the impact of intervention efforts.

A new intervention, based on surveillance data, is the SENSOR Project (Sentinel Events Notification System for Occupational Risks). Ohio is one of 10 states receiving funding from the National Institute for Occupational Safety and Health (NIOSH) to participate in the SENSOR program.

For reporting forms or additional information, please contact the Ohio Department of Health, Division of Occupational Health, P.O. Box 118, Columbus, OH 43266-0118, (614) 466-4183.

Winners of the OSMA Golfers Tourney . . .

One hundred twenty-seven physicians, sponsors and guests competed in the 64th Ohio State Medical Golfers Association Tournament this past June at the Country Club of Ashland, Ashland, Ohio.

Low gross honors were claimed by James F. Rambasek, MD, of Middleburg Heights. Dr. Rambasek shot a 76, and his name will be inscribed on the Richard P. Bell Trophy.

Richard B. Ogle, DO, of Mt. Vernon claimed overall low net honors with a 64 (78 less 14 handicap). Dr. Ogle's name will be inscribed on the Dr. Ray Stephens Memorial Trophy.

Winner of the Dr. Carm Shamess Memorial Award for Most Improved Golfer, Scratch, from 1988 to 1989 was Henry A. Wise, MD, of Columbus. Dr. Wise chopped eight strokes from his 1988 total. The Shamess Award for Most Improved Golfer, Net, was presented to Bruce P. Meyer, MD, of Columbus, who cut six strokes from his 1988 net score.

Winners in age flights were as follows:

Low Gross, Age 39 and Under — James J. Wysor, MD, Sandusky (77)

Low Net, Age 39 and Under — Mark E. Frazer, MD, Middletown (70)

Low Gross, Age 49 and Under — James E. Bagenstose, MD, Lima (83)

Low Net, Age 49 and Under — Dennis P. LeGolvan, MD, Toledo (75)

Low Gross, Age 59 and Under — (tie) Ralph Ballenger, MD,

OHIO MEDI-SCENE

Winners of the OSMA golfers tourney . . . *continued*

Columbus & K.S. Kang, MD, Elyria (78)

Low Net, Age 59 and Under — Semur P. Rajan, MD, Mansfield (69)

Low Gross, Age 69 and Under — John C. Stahler, MD, Dayton (81)

Low Net, Age 69 and Under — Donal R. Ross, MD, Bay Village (71)

Low Gross, Age 70 and Over — Thomas W. Jackson, MD, Wooster (89)

Low Net, Age 70 and Over — Al Voegele, MD, Mansfield (71)

In the second year of competition in the OSMGA Women's Division, low gross honors went to Merilee Gallagher, MD, of Shaker Heights. Dr. Gallagher shot a 101. Low net honors went to Marjorie Gallagher, MD, of Columbus, with a 92. The Gallagher sisters joined their father, Clarence M. Gallagher, MD, of Columbus, in the 1989 OSMA competition.

Winners in the sponsor-guest competition were Gary Anania of Mansfield with a low gross score of 81, and Rodney Graber of Bellefontaine with a net of 79.

In the accuracy and distance contests, honors for closest tee shot to the pin on the par 3 No. 3 hole went to Grant Morrow, III, MD, of Columbus, and James J. Wysor, MD, of Sandusky hit the longest drive in the fairway on No. 12.

During the awards banquet, OSMGA President David M. Bell, MD, paid tribute to William M.

Above: *A Knox County foursome prepare to tee off during the 1989 OSMGA Tournament at the Country Club of Ashland, Ohio. From left to right: James R. McCann, MD; Jack Tidyman, MD; Alan K. Fairchild, MD; and Richard B. Ogle, MD. Dr. Ogle won overall low net honors in the competition.*

Left: *James F. Rambasek, MD, Middleburgh Heights, captured low gross championship in the tournament.*

Semur Rajan, MD, *Mansfield — low net honors, 59 and under competition.*

Family affair: *(above) Sisters Marilee, left, of Shaker Heights and Marjorie, both physicians, participated alongside their father Clarence M. Gallagher, MD, Columbus. (Below) Brothers Gilman D. and Robert C. Kirk, both physicians from Columbus, have competed in the OSMGA Tournament for more than 30 years.*

(All photos taken by George W. Loesch, MD, Mansfield.)

Tied for low gross honors, *59 and Under, were: Ralph Ballenger, MD, Columbus (left) and K.S. Kang, MD, Elyria.*

Emery, MD, of Ashland, a longtime OSMGA member who has been instrumental in bringing the tournament on several occasions to the Country Club of Ashland; David Mason, general manager of the Country Club of Ashland; Golf Professional Davey Snyder and Assistant Golf Professional David Beddard.

Also receiving praise for outstanding work in registering the 127 golfers were Karen Emery, Diane Brechbuhler, Nancy Davis, Ruth Smith, Charmaine Stencel, and Peggy Yoder, all of Ashland, and Ann D. Clinger of Columbus.

Dr. Bell recognized the sponsors for the 1989 OSMGA Tournament and their representatives, as follows:

Physicians Insurance Company of Ohio (D. Ross Irons, MD, Robert L. Dion, Mark Hannan). This marks the 11th consecutive year that PICO has been a major sponsor of the OSMGA.

ICL Leasing, Inc. (Brian Blake, Mike McHugh and Steve Sansbury). This was the sixth consecutive year for ICL Leasing, Inc., as a sponsor.

Wyeth-Ayerst Laboratories (Gary Anania) served as a sponsor for the fourth consecutive year.

Hoechst-Roussel Pharmaceuticals (Gary McCreery) was a sponsor for the second consecutive year.

Also serving as sponsors for the second consecutive year were Smith Kline & French Laboratories (Susan Schoen and Jeff Palmer) and E.R. Squibb & Sons, Inc. (Ellen Weaver-Bailey).

Dr. Bell welcomed as first-year sponsors PIE Mutual Insurance Company (John P. Doyle) and the Presidential Group, Inc. of Loudonville (John T. Donley).

The OSMGA is currently seeking a site for the 1990 tournament. Possible sites include the Springfield County Club and Bent Tree Golf Club near Sunbury.

Robert D. Clinger, Staff, Ohio State Medical Golfers Association

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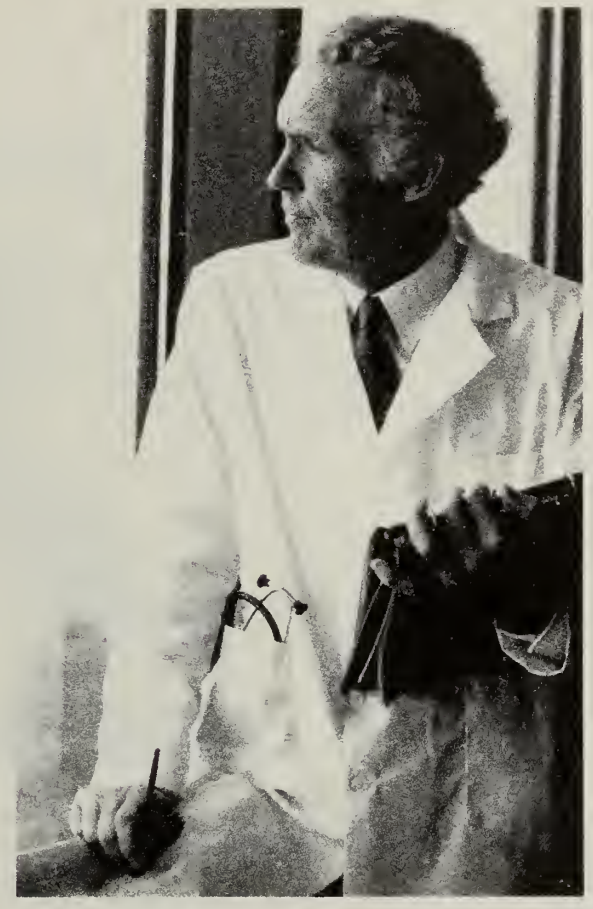

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Editor's note: *There is never a dull moment at the OSMA offices in Columbus, or at other locations around the state for that matter, as physician-members meet to discuss important medical issues, and to plan strategies that will keep the patient at the top of the state's health-care agenda. This month, OHIO Medicine begins a new column that will keep you abreast of some of the numerous activities in which OSMA members participate to accomplish this goal. It is through the dedication and efforts of these individuals that health care in Ohio continues to be among the best in the country. To those pictured here, and to those whom we will portray in the future . . . thanks.*

OSMA-OHA identify common problems

The officers of the OSMA recently met with the officers of the Ohio Hospital Association, which represents the interests of hospitals in the state of Ohio. The purpose of the meeting was to identify common problems and interests. OSMA officers pledged to continue to meet with the OHA as needed so that the two groups may work more closely together.

William Marshall, MD *(left), OSMA President, and John A. Devany, MD, OSMA President-Elect, listen carefully to points being made by OHA officers.*

OSMA-OHA members *convened at OSMA headquarters to identify common problems and interests.*

William C. Kelly, Jr., *President of Samaritan Hospital, Ashland, was one of the hospital officers who attended the meeting.*

Ohio receives Outreach award

Donavin A. Baumgartner, Jr., MD, *recently accepted the AMA's Outreach Award for outstanding achievement in recruiting new members to the AMA. Ohio recruited 47 new members, and was one of five states to receive the AMA award. (For further information on this award, and other activities of the OSMA's Committee on Membership, see page 717).*

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Committee on Accreditation meets

The Committee on Accreditation *meets to discuss accreditation of hospitals and other facilities' CME activities, as well as proposals concerning the CME activities of the membership.* **John O. Lindower, MD** *(l.),* **Alvin E. Rodin, MD** *(center) and* **Harvey J. Dworken, MD** *(r.).*

(For a report of the newly reactivated Committee on Judicial and Professional Relations, see page 683.)

John D. Kramer, MD, *Akron, chairs the Accreditation Committee.*

Albert N. May, MD, *Marion . . . a long-standing member of the committee.*

The Fels Study:

Research Infinitum?

By Karen S. Edwards

For 60 years, Fels study participants have been measured, weighed, floated and pinched. What has medicine learned as a result?

Alexander Roche, MD, PhD, is an Australian who bristles when his thick, clipped accent is mistaken as British.

"That's an insult," he says, feathers ruffling just slightly.

But it's the good doctor's work in Yellow Springs, Ohio — not the land down under — that's earning him a niche in medical history.

Dr. Roche is principal investigator of the Fels Longitudinal Study of Human Growth and Development, the longest-running human research project in the world. (It pre-dates the better-known Framingham study by a good 30 years.)

For a little over 20 years, Dr. Roche has measured, weighed, floated and pinched three generations of Fels study participants — all in the name of science, of course. And science, or at least medical science, has benefited immeasurably as a result.

"The Fels study was begun as the result of a general White House conference on children," Dr. Roche says in his distinct, *Australian* accent.

That was in 1929, when Herbert Hoover was President and Wall Street took the notorious financial nosedive that would signal the start of this country's economic depression.

You wouldn't expect medical research to flourish in such a cost-restrictive environment, "but the conference discovered there were large gaps in our knowledge about children and their growth habits," says Dr. Roche — and, suddenly, "growth studies" sprang up everywhere . . . from Berkeley to Boston to Yellow Springs, Ohio.

Dr. Roche didn't become a part of the Fels study until 1968, when a hastily arranged interview during the layover of a business trip between Melbourne and Europe materialized in a job offer.

John Kramer, on the other hand, has been involved in the study from year one.

Kramer, a Xenia carpenter, and his two brothers were the first triplets to become involved in the Yellow Springs study — reason enough, in 1929, for researchers to waive the newborn age requirement. Generally, Fels investigators want to begin collecting data from the first day of birth, or soon thereafter, but triplets — even at one year of age — were just too good a genetic study possibility for investigators to pass up.

"We are interested in genetic factors," Dr. Roche admits, adding that of the 1,000 participants in the Fels study, 90% of them have blood relations in the program.

"The Fels study is not so much a study of individuals as much as it is a study of families."

Kramer, for example, has enrolled his six children in the study, and now 10 of his grandchildren are Fels participants.

For the Kramers, the study has assumed something of an air of family duty, a responsibility that is handed down from one generation to the next.

"Oh, the kids grumble about the tests from time to time. I think they can take them or leave them. But they always go," says Kramer.

The frequency of the tests declines with age, a factor Kramer says encourages him to stay involved in the program.

"It's not so bad anymore," he says. "I only go in for tests every couple of years now."

Tests for younger participants are more frequent, of course, and according to Kramer, more varied.

The Fels study, however, no longer confines itself simply to growth measurements — although 30 growth measurements are still taken "to help us estimate other data," says Dr. Roche.

In 1976, however, the study's purpose took a different direction.

"It occurred to me that the questions and hypotheses being posed by the Fels data was good from the point of view of a

The Fels study now reveals that fat distribution is important when attempting to determine risks to your patients . . . and not just for heart disease.

physical anthropologist, but that none of the data were specifically health-related," says Dr. Roche.

In essence, the Fels study was stagnating.

It had completed its task — in fact, so well that its detailed picture of pubescent growth spurts enabled the National Center for Health Statistics to develop body growth charts, now used worldwide by physicians and researchers.

"But if we had stayed within the scope of the original Fels study, we would have gone out of business long ago," Dr. Roche claims.

So, in the late 1970s, the Fels study turned its attention to a popular research subject — heart disease.

The Fels program has now set its data-collecting sights on determining when such factors as body fat distribution, cholesterol levels and high blood pressure in children become risks for cardiovascular disease.

"Our goal," says Dr. Roche, "is to establish the extent to which childhood values predict adult values in normal populations . . . and whether or not those factors are genetically passed on through generations."

As a result, participants now submit to a battery of new tests which produce detailed reports of their cholesterol levels and body composition.

"We use calipers to measure skin folds and we determine body density by underwater weighing and impedance," says Dr. Roche.

Already, some surprising information is beginning to emerge from the data that has been collected over the past 13 years.

For example, the myth that fat babies become fat adults is not substantiated by the study.

"The risk factors present in infants under two may disappear in adulthood, so fat infants do not necessarily make fat adults," says Dr. Roche.

However, chubby toddlers — at least those over the age of two — may find themselves battling weight problems on into adulthood.

"Three appears to be the cut-off age," says Dr. Roche, and the skin-fold test backs him up. "We've found that a high thickness in a child over two is shown to correlate to a high thickness in the adult."

The index Dr. Roche now uses to determine the value of body fat is a simple one that he says can be easily adopted by Ohio clinicians.

"It's body weight, divided by stature, squared," he reports.

He also recommends impedance (in which a small alternating electric current is sent through the body), as an excellent means of determining body composition. "The test is simple, harmless and the equipment is inexpensive and portable. I would recommend it to those clinicians who may have a number of obese adults in their practice."

Yet the presence (and amount) of body fat is only half of the story.

The Fels study now reveals that fat *distribution* is important when attempting to determine risks to your patients . . . and not just for heart disease.

According to study results, for example, the more fat you find in abdominal areas, the greater that patient's chance for adult onset diabetes.

"Abdominal fat is a common masculine characteristic," says Dr. Roche. "I'd caution a clinician who might have a male patient with a large abdominal area to screen him for diabetes."

Large amounts of fat in the hip region, however, seems to offer more protection — actually reducing the risk for diabetes, continues Dr. Roche.

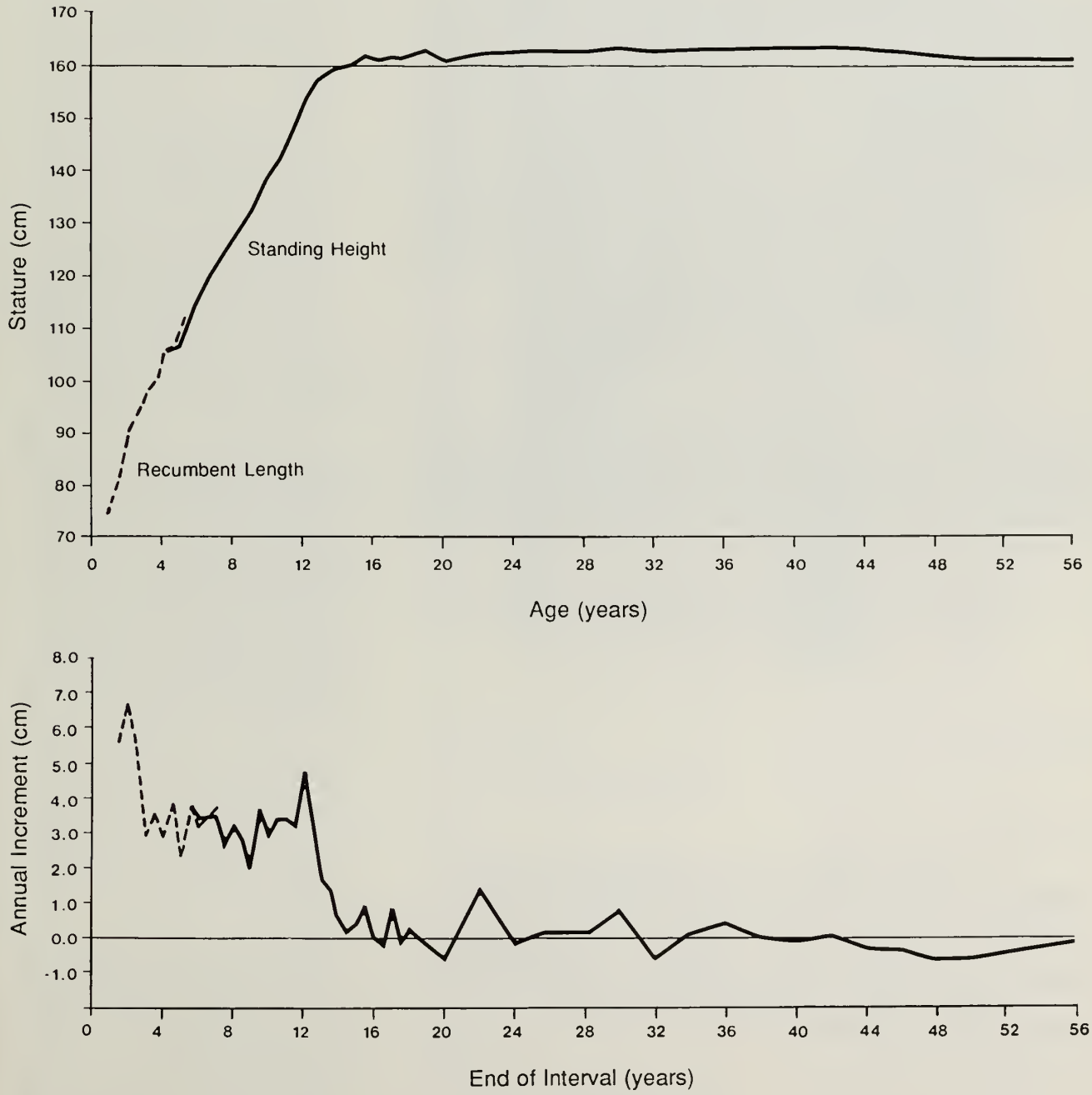
"We think that's because big, broad hips are associated with bigger frames, which are naturally more protective."

Fat in both the abdominal and hip areas can be reduced, of course, by an all-over weight-loss program. In fact, says Dr. Roche, it is the only way to reduce this fat . . . those "spot exercise" programs that focus attention on "problem areas" just don't work by themselves, he continues.

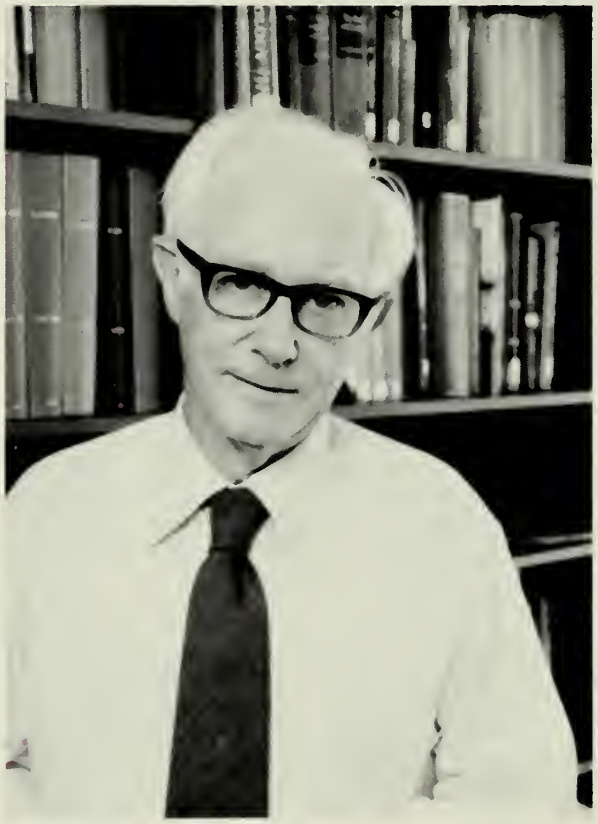
Nor will it do your patients any good to complain about heavy thighs.

"Thighs are not responsive to those things that normally reduce fat and weight, like a diet and exercise plan," says Dr. Roche.

In fact, study results show that



Six Decades of Data: Two graphs illustrate one of the longest serial records in the Fels Longitudinal Study of Human Growth and Development. The graphs are based on measurements of one of the Fels study's first participants, who was born in 1929. The top graph tracks the participant's growth in stature up to age 56. Recumbent length was measured until the participant was age 6, then standing height measurements were recorded. The lower graph displays the participant's annual increments of change in stature. The participant grew the most during years 3 and 12.



Alexander Roche, MD

"It's like asking when General Motors will go out of business. As long as they have cars to sell, they won't . . . as long as we can learn something from the data we collect, we won't either."

the only way your patients — at least your female patients — can expect to see any size reduction is when they are breast-feeding their infants.

"Lactation is the only response that has proven effective in the data," says Dr. Roche. "It's as though Mother Nature designed those thighs for a purpose . . ."

Even now, the Fels study continues to uncover more data on the subject of fat distribution and body composition, and later this year a milestone of another sort will be marked when the 1,000th scientific paper, based on the study's data, will be presented.

So far, there appears to be no end to the study in sight.

"When the study was started," recalls Dr. Roche, "a target was set to study the infants until they were 16 years of age." That was later amended to 18 years — and from 18 years, it was a short, mental hop to adulthood.

"Theoretically, the study should end upon the death of the participants," continues Dr. Roche, "but we're enrolling new participants all the time." And, since they are all somehow related to each other, the Fels study does indeed seem to have the capability of stretching the research of its earliest participants on *ad infinitum.*

The only concern, of course, are dropouts — yet, according to Dr. Roche, the annual dropout rate of the study averages only about 1 participant per 600.

"Most participants are enthusiastic about the study," says Dr. Roche.

Or, perhaps, feel an obligation to continue.

John Kramer says he has no plans to retire from the study that

has consumed a large part of his life for some 60 years now.

He'll tell you he's used to the prodding and poking and unusual requests by now.

"Once, they told us to grow a beard, then they had us shave it off, and they counted our whiskers," he recalls now, with a chuckle.

On yet another occasion, researchers were sent to school with the Kramer triplets — to record their class performances, their socialization skills and other observations.

"Yeah, it was a little embarrassing to be followed about like that, but you have to understand that as triplets, we always dressed alike and socialized together, so we were used to attracting attention anyway."

Triplet . . . Fels participant. For Kramer, the novelty has always been there.

"But I do feel as though I'm contributing something to society," he says. "In the long run, I guess that's why I do it . . . why I continue."

And as far as Dr. Roche is concerned, the data he and his investigators continue to collect on Kramer and his family — as well as the other participants — will continue to be of service for decades to come.

"The study will run out when the money and the questions and the productivity run out," says Dr. Roche. "It's like asking when General Motors will go out of business. As long as they have cars to sell, they won't — and as long as we can learn something from the data we collect, we won't either."

The National Institutes of Health agrees, and recently extended the study for another five years by awarding it a $4.8 million continuing grant.

John Kramer (far left), pictured here at about five or six months of age with his triplet brothers Henry (center) and Fred, has participated in the Fels study since 1929. Now, Kramer's children are participants, as are 10 of his grandchildren.

"It's data base is a national treasure," an NIH review group once remarked about the Fels project.

It's a long way to come for an independent growth study, once financed by the Fels Naptha Soap Company. Now, Fels is affiliated with the Wright State University School of Medicine, which allows the study to draw upon the school's extensive personnel and equipment.

"The equipment has certainly become more sophisticated over the years," quips Kramer — and so too has the study.

"I've no doubt that, over time, the slant of the study will be changed," says Dr. Roche. "I'll retire and the investigator who will follow me will say 'this man was out of his mind. We need to use the study A, B or C.' "

Dr. Roche won't predict what direction those future slants might take.

"We do have to do some fancy footwork to collect data for questions that will still be relevant years from now," he says, thoughtfully. "But then we will have all the preceding data to draw on. Using the longitudinal study, we can calculate correlations that no one else can calculate."

He's pleased about that, about the study's flexibility — and its perpetual nature.

And it does seem more than likely that long after Dr. Roche's retirement, *someone* in Yellow

Fels Study . . . *continued*

Springs will still be weighing and measuring, floating and pinching Fels study participants, as part of the longest-running human research project in the world.

. . . And it's just as likely that medical science — and society-at-large — will still be benefiting as a result. **OSMA**

Karen S. Edwards is Executive Editor of **OHIO Medicine.**

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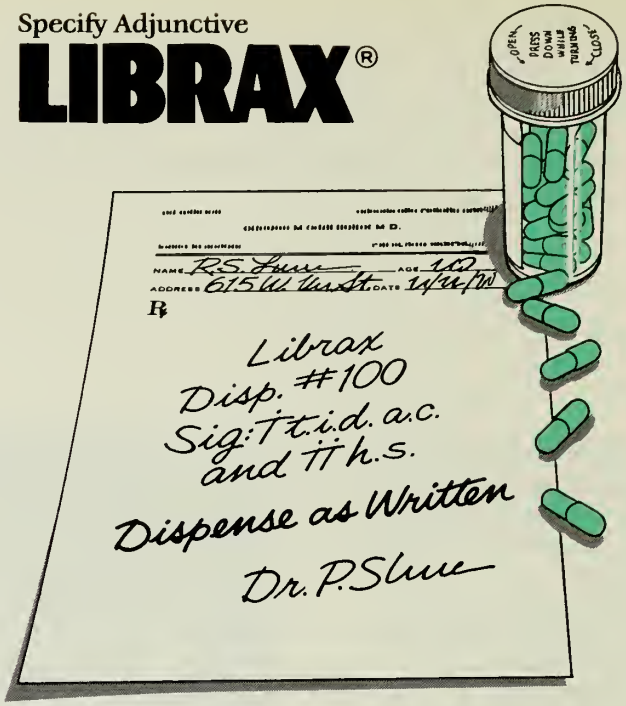

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Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

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Medical V·i·d·e·o·s

Glitzy new teaching tools for physician and patient

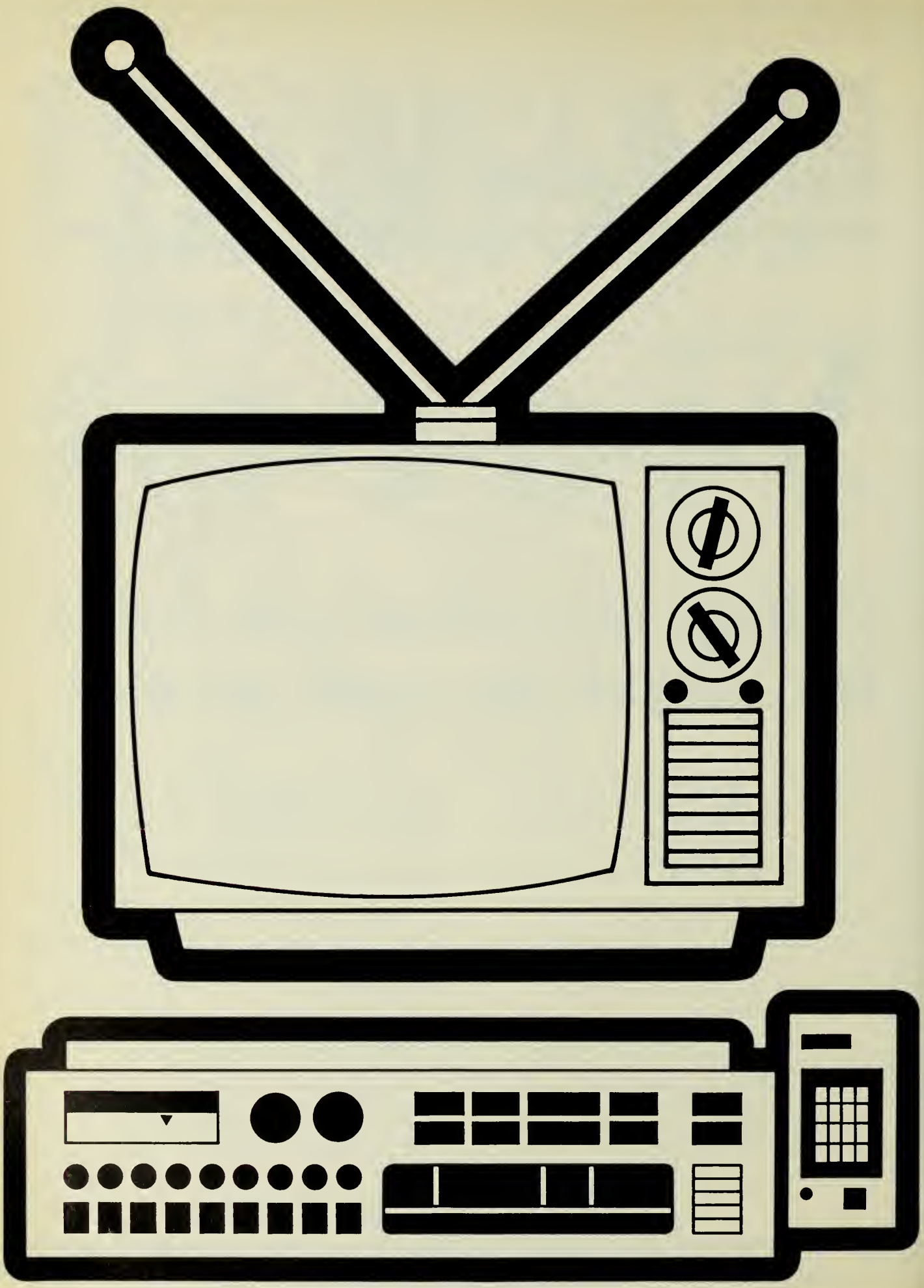
A patient leans back in a cushioned chair as the lights in the room are dimmed. The familiar click of a tape being inserted into a VCR can be heard, and then the credits begin . . . The film's title is "So You're Going to Have Surgery." As the patient's physician, you feel the video may relieve anxieties and answer questions the patient has about his or her upcoming operation . . .

A scenario such as this may now become commonplace during a visit to the doctor's office. It's not surprising, really, considering the rate at which videos have infiltrated most of our lives. With the steep price of movie tickets, VCR movie rentals have become a blistering-hot commodity. And who would have guessed that music videos would become one of the biggest cultural outgrowths of the 1980s? MTV has left some parents eternally grateful that it's possible at times to have "progress with an escape hatch" — a phrase coined by John Updike — which, in this case, amounts to the TV set's on/off button.

Worth 1,000 words

Video broadcasting has gone far beyond capturing the catchy dance beats and new haircuts on MTV, however. For example, physicians are now using videos to educate their patients about upcoming

By Deborah Athy



"Without a doubt, (videos) help the patient's understanding. Usually, when you say you're going to do surgery, it goes in one ear and out the other . . ."

operations and techniques. In many cases, the patient will sit with family members during the screening, which is often done, just like in the home, with a VCR and TV screen, explains Martin Markowitz, MD, a Cleveland ophthalmologist who has been using medical videos in his practice for about the last decade.

Dr. Markowitz includes the video as part of the examination and then answers the patient's questions when the video ends. "Without a doubt, they (videos) help the patient's understanding," he says. "Usually when you say you're going to do surgery, it goes in one ear and out the other. The patient hasn't heard a word you're saying." But translating those words onto a screen puts the procedure in a more understandable context, he says. As they say, "A picture's worth a 1,000 words," he adds.

Dr. Markowitz was introduced to the idea of using patient educational videos about 10 years ago at an ophthalmology meeting in which there was a video presentation. "I was impressed," he remembers.

Since then, he has collected about eight videos — enough to cover all the surgical procedures that he does. "The patients love it. About 99% prefer to watch."

Living color

Another physician from Davenport, Iowa, takes the magic of videos a step further. He allows a patient's family and friends to watch the actual surgery on closed-circuit TV. Then, if requested, the physician provides the family with a videotaped copy of the operation, complete with voiceover narration and background music by Bach. The tape may not become a standout at family gatherings, but it does make the operation more accessible to the patient and the patient's family.

No more paper journals?

Physicians are also more inclined than in the past to learn new medical procedures by watching videos. Medical videos have come a long way since the educational films of the past. Those old films always seemed to have a distinctly gritty quality — with black specks flickering across the screen and a flat, static-filled narration.

"There's no room for error in video," says Alice Burgess, President of Medical Videos Productions (MVP) in St. Louis. "That's why so many videos to date have been so amateurish."

But Burgess says the tide is turning. As in almost every other facet of American society, the wheels of progress are turning in video production. Videos are not only more plentiful than in the past, but their quality is generally better than before, she says.

"We're overcoming the decades of amateurish, home movie-style medical videos that physicians had in the past," she says. Previously, "There was a preperception of poor quality in medical films."

But audiences are now much more sophisticated. "Physicians won't tolerate anything less than broadcast quality," Burgess says. And as the market continues to upgrade its products, she expects that medical video use will continue to increase.

Burgess' company may tempt some physicians to throw away some of their medical journals, because MVP provides medical journals on video. Subscribing physicians receive six issues a year in specialties including cardiology, ophthalmology, OB-GYN and orthopaedics. The company is also eyeing radiology and general surgery as potential markets.

Each MVP issue includes three author presentations. A recent installment of the Video Journal of Orthopaedics included demonstrations of arthroscopic shoulder reconstruction, the first video publication of Cine/MRI, and a disc of the "parachute effect" in primary total hip

The videos give the physicians an opportunity to see how a surgeon approaches a certain operation and get a feel for the actual medical environment.

arthroplasty.

The videos give the physicians an opportunity to see how a surgeon approaches a certain operation and get a feel for the actual medical environment, Burgess explains. "The challenge (to us) is to merge broadcast quality with a technical level that physicians will be interested in."

The video journals have currently attracted about 14,000 subscribers. "They're well received by a substantial proportion of physicians," Burgess reports. Subscribers are "usually younger, procedurally oriented and in fields where there are a lot of new developments. It's that combination of factors that make a certain specialty or group of physicians more interested in video."

The new MTV

Physicians are not only able to have medical journals put on the screen, they can, depending upon where they live, tune in to specially designated TV stations — MTV, or medical television.

In Cleveland, for example, PBS Channel 25 provides medical programming to all hospitals within a 25-mile radius. About 27 hospitals are currently using the service, which became available in July 1986.

The programs cater to both health professionals (topics include infectious diseases, geriatrics and AIDS) and the public (topics include preventive medicine and good health habits.)

The channels are licensed to air educational TV, says Peg Neeson from WVIZ in Cleveland. So it's "natural, especially in northeast Ohio, to provide hospitals with programming," she explains.

Films galore

There's also an abundance of companies producing a highly ramified selection of patient and physician educational films. Commonwealth Films in Boston, for example, primarily produces films for the public. Two of its videos described in a recent press release included "Just the Facts" — a 23-minute film geared toward hospital staff about incident reporting — and "AIDS, Hepatitis and the Emergency Responder," aimed at health-care personnel who are at high-risk for these diseases.

Another video company, Modern, in Petersburg, Florida, sent a press release advertising "Don't Be Blind to Diabetes," a film for patients that can be ordered on a free-loan basis.

These companies represent only a few drops in what seem to be a deluge of companies getting into medical video production.

The final frontier — medical film festivals

Perhaps nothing speaks as well for the popularity of medical videos as does the fact that they now have their own version of the Cannes Film Festival.

The John Muir Film Festival, which originated in California in 1976, was a brainchild of a John Muir Medical Center ophthalmologist who wanted "to encourage production and distribution of the finest audiovisuals by recognizing and honoring their producers," according to the foreword in the festival's catalogue. The 80-page festival catalogue offers reviews of nearly 500 videotapes and videodiscs.

If you suspect that this festival is not nearly as star-studded as its French counterpart, consider some of the members of the festival's National Advisory Board: Walter Matthau, Judith Crist, Art Ulene, MD, Tom Bradley, Dianne Feinstein, Shirley Jones and Neil Simon. Not exactly Brando and Spielberg, but a pretty impressive list.

This year's collection of films included over 50 entries on AIDS. One of these hailed from the

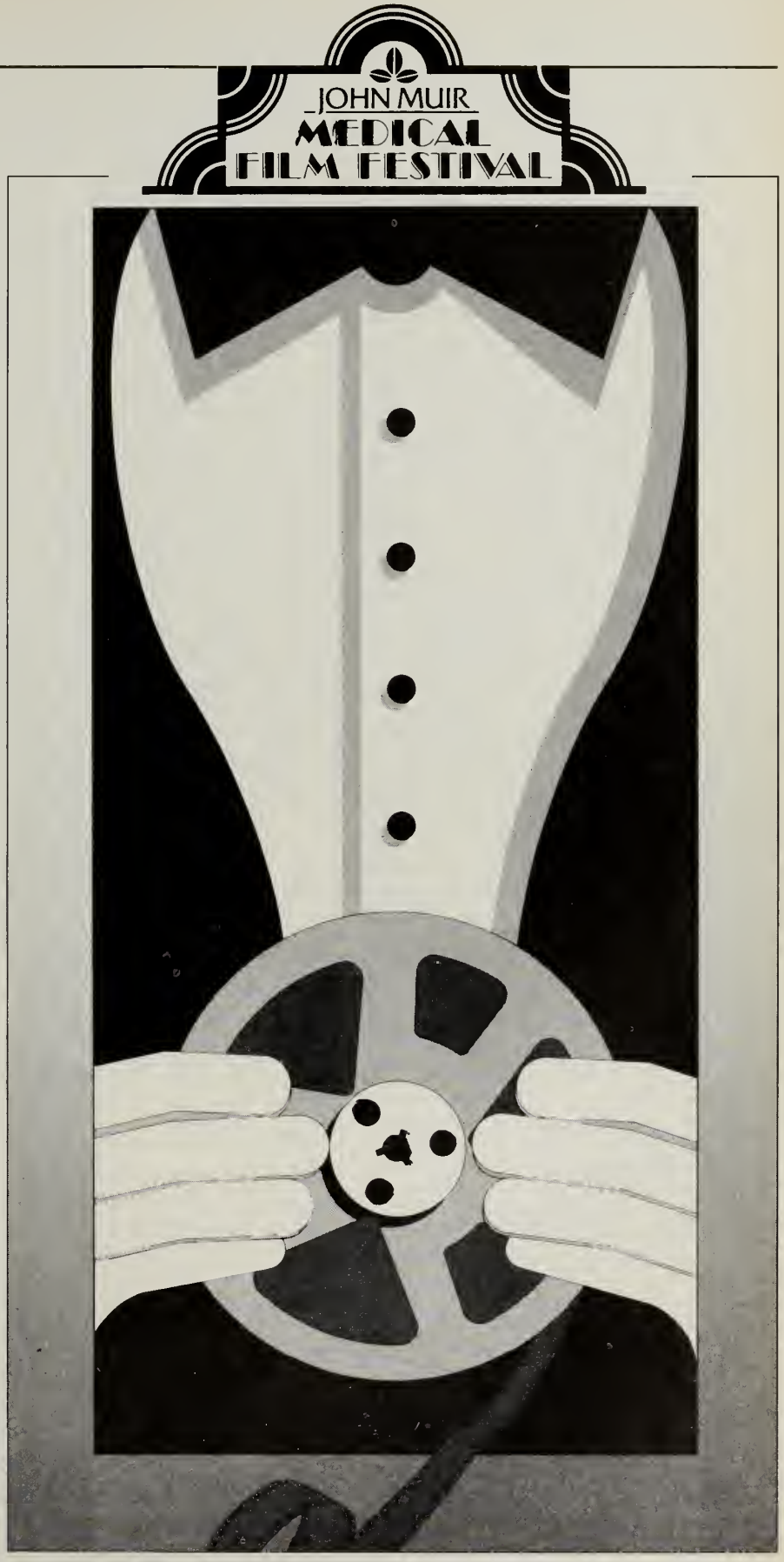
Cleveland Academy of Medicine — "The Physician's Role in the AIDS Epidemic." Other films were geared toward patient education with such titles as "Newborn Care," "Insulin Use" and "Diet, Exercise and Self-Care," while others focused on physician education — "Hypertension Update," "Sexual Abuse of Children" and "Cancer Discussion — Communicating the Diagnosis to the Patient."

Some of the award-winning films in the festival included:

- "D-I-S-E-A-S-E." A rap music video to teach AIDS prevention to teens.
- "Cardiac EchoDoppler." Four medical observations of the echocardiographic doppler.
- "A Long Night With Lethal Guests." A community health video about preventing malaria in New Guinea.
- "Close Encounters of the Sexual Kind." A program that looks at fact and fiction about sexually transmitted diseases.

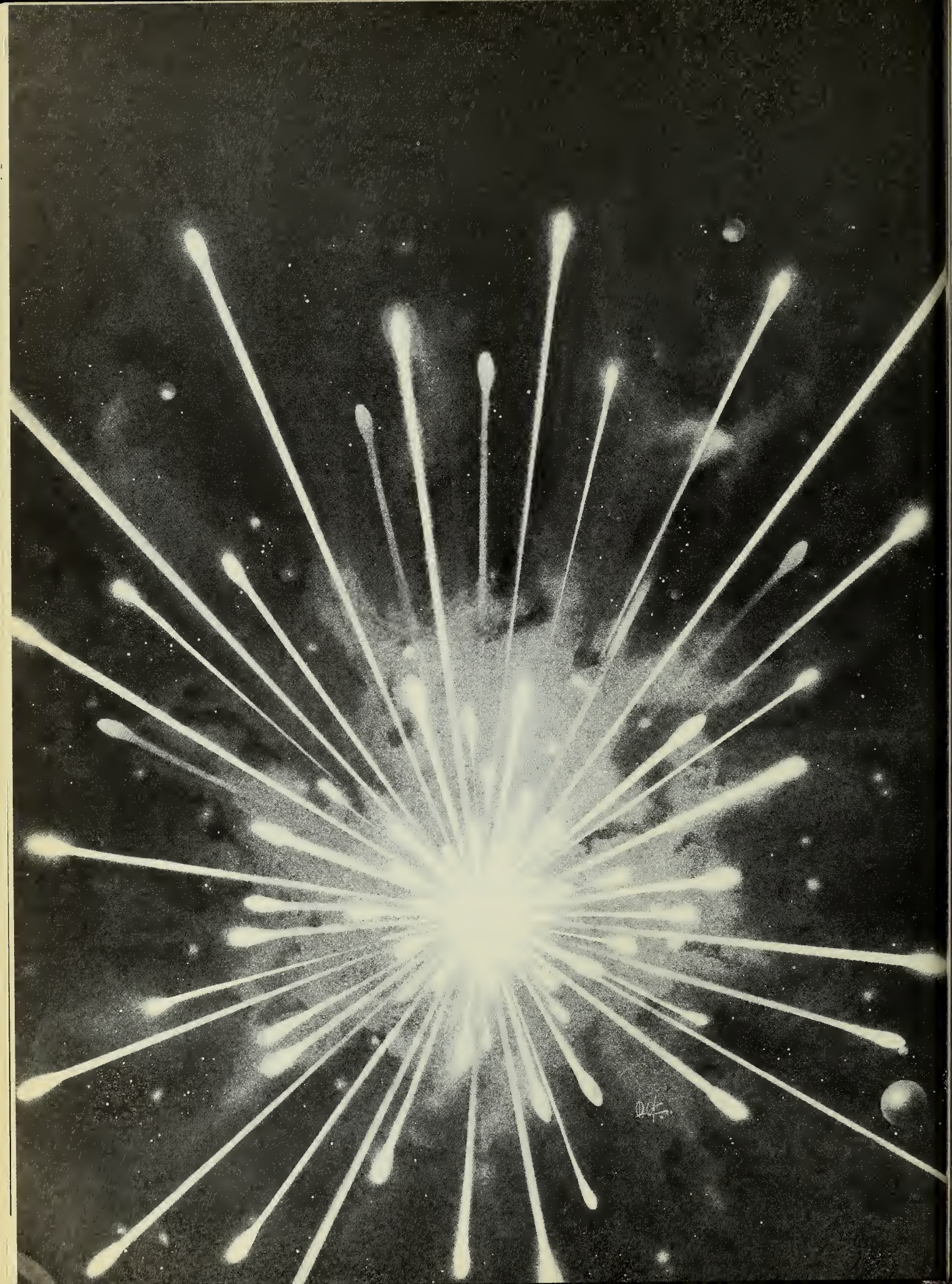
Whether it's in the doctor's office, the doctor's study, the classroom or the nursing station, it seems that medical videos are gaining more and more supporters. Maybe it's because the new videos have more substance, more style . . . or maybe it's because the time is right.

"One of the greatest challenges an educator faces is how to spark interest in the student," the president of the John Muir Medical Center points out. "The teaching tools we use must be professional in format, content and presentation or the learner will quickly tune out." By the sound of things, medical videos may be the teaching tools of choice for the future. **OSMA**



The medical film festival, such as the annual John Muir competition, may be the medium's final frontier.

Deborah Athy is Associate Editor of **OHIO Medicine.**



They've been around since 1960, but lasers are still underused by the medical profession. Why? Could it be, as one surgeon attests, that most physicians are laser illiterates . . .?

Are You Laser-Literate?

By Michelle J. Carlson

They've been around since 1960, but when it comes to lasers, most physicians are still "laser illiterates."

At least that's the contention of Stephen Joffe, MD, a general surgeon and a founder of Laser Centers of America in Cincinnati, a health-care consulting company that helps hospitals implement laser programs.

"Utilization (of lasers) is incredibly low," says Dr. Joffe, who likens the situation to the computer era: When computers first came out they were difficult to understand, expensive to buy and above all, perhaps, intimidating. Once computers became more affordable and user-friendly, they could be found everywhere — in schools, businesses and homes.

"The same thing is true of lasers in the medical field," says Dr. Joffe. Laser technology and its applications in the medical field have grown immensely over the last three decades (see sidebar story), but unlike the computer craze, physicians have been slow to catch on. "Most physicians," he says simply, "are not what I call laser-literate."

Part of the problem may be that many hospitals simply can't afford to purchase lasers, says James S. McCaughan, MD, director of the laser center at Grant Hospital in Columbus.

In order to establish a program, "You have to have a laser, and a laser costs about $100,000," says Dr. McCaughan, adding that the problem is not isolated to small, community hospitals.

"Large university hospitals in general have been way behind," he says. "There's too much bureaucracy."

Dr. Joffe, however, disagrees. "No, most hospitals *do* have lasers," he says emphatically, noting that lasers run anywhere from $25,000 to $100,000 — well within most hospitals' budgets. "I think most (hospital) administrations would have no problem putting them in if they thought they'd be used," he says, but the lack of physician knowledge, the lack of knowing what lasers to buy, sometimes prevents them from doing so. Hospitals and physicians might also be intimidated, he says, because "You have to have an integrated system" that offers a variety of lasers and procedures in

"The laser, as a tool, is a very wonderful thing, but to make the claim that it's the answer to all surgery and (is) painless is very misleading."

order to render a program cost-effective.

Perhaps a bigger part of the problem, he says, is that "(Physicians) aren't experienced. They're not all that interested. There's tremendous apathy. (Doctors say) 'Why should I change? It's the same way I've always done it. Why should I have to learn something different?' "

Lest one think that it is older doctors unwilling to accept new medical technology, think again.

"Age is not a factor. Everyone thinks it is, but it's not," says Dr. Joffe. "We've had as much success teaching younger physicians how to use a laser as we have teaching physicians who are about to retire."

Whether they want to incoporate laser surgery into their practices or not, physicians are already finding that patients are demanding it, says Dr. Joffe. "The patient consumer is now more informed than some physicians," he says. "Patient knowledge is great.

"They are well informed and their expectations are reasonable. (They know that with laser surgery) they basically have a surgical operation with less bleeding, the ability to get out of the hospital sooner, get back to work sooner."

Not only are they well informed, Dr. Joffe continues, "They'll shop around until they find a physician who can carry out the operation in the easiest, quickest, most effective way."

The pressure to offer laser surgery is only going to escalate in the coming years, says Dr. Joffe.

"They are going to be driven to it by patients who demand it . . . the health-care system, the whole reimbursement system," he says, because laser surgery cuts hospital costs.

"It's going to snowball with greater awareness."

Some physicians, however, aren't so sure that prospective patients aren't being misled by laser technology, that maybe they're being sold on the idea that laser surgery is the only way to go.

At least, that appeared to be the implication in a recent *Dayton Daily News* article, which quoted William K. Rundell, MD, a Dayton general surgeon, as saying "The laser, as a tool, is a very wonderful thing, but to make the claim that it's the answer to all surgery and (is) painless is very misleading." The article noted that the Dayton Surgical Society, of which Dr. Rundell is a member, recently introduced a resolution asking its members "to advise hospitals in appropriate marketing to avoid exaggerated or unproven claims" in its advertisements. While the resolution doesn't specifically name lasers, Dr. Rundell said that they were considered when the resolution was being discussed.

Physicians are also addressed in the resolution, which continues: the "society does not support or condone excessive fees to surgeons utilizing such new equipment as a substitute for conventional instrumentation."

Dr. Rundell was also quoted as saying that "Our concern would be that a surgeon be careful not to jack up his fee because he did something with a laser that could have been done another way."

But Thomas Heck, MD, also a Dayton general surgeon, and past president of the Dayton Surgical Society, says that the emphasis on lasers by the newspaper was blown out of proportion.

"The intent of that motion," he says, "was to say, 'Hey look, make sure you've got sound medical research before you take (new technology) to the public' . . . It incorporated lasers, but it also incorporated other technologies. This was not directed just at lasers."

Laser technology, he continues, has not been overpromoted to the public. "Certainly it has raised a lot of interest . . . It is a new technology — across the country in general — and people are very inquisitive." But, he adds, "I think (lasers) are being used appropriately." **OSMA**

New applications for an old idea

Reporters who 30 years ago accused the father of the laser as having invented a science fiction death ray probably never dreamed that any good would ever come from such a "diabolical" device.

Back then, Theodore Maiman, the California physicist who invented the laser, constantly had to defend his discovery. "People would ask, 'How do you feel about inventing something so destructive?' " he said recently at a laser center opening in Cleveland. But "the 'death ray' myth is a misnomer. I don't know of anyone killed by a laser, but I know people who have been healed by it."

Today, not only has laser medicine proven its value, over the years it's grown by leaps and bounds. Listed below are just a few of the latest applications for lasers, all of which are available in Ohio.

• **The tunable dye laser.** This laser, which has been around since 1988, is being used in the treatment of port-wine stains. Because scarring was always a very real possibility when using the old treatment (argon lasers), this new laser is considered a breakthrough. According to James S. McCaughan, MD, the director of Grant Hospital's Laser Center in Columbus, using the tunable dye laser "means you can tune it to get different wavelengths." Specifically, he says, using the yellow-colored wavelength produces better results than the blue-green wavelength of an argon laser.

• **The contact laser.** This tool, which was approved by the Food and Drug Administration late last year, can offer more precision than conventional noncontact lasers because physicians can actually touch the laser to body tissues. Some surgeons say this ability gives them a better "feel" of what they are doing, similar to working with a scalpel. Dr. McCaughan says that the laser "has a tip on the end of the fiber, and you do touch the tissue . . . you get less damage (and) it's more precise."

One supporter of the contact laser is Burton Evans, MD, a Cincinnati proctologist, who uses the device to perform hemorrhoidectomies. Dr. Evans cites the laser's "tactile sensation and accuracy" as advantages, adding that "You feel what you're doing — you're not just shooting a beam."

• **Laser opacity lensmeter.** This device, which is currently being used in about a dozen hospitals around the country, is a painless way of measuring opacity in the eye. Opacity is measured on a scale of 0-99, with 99 being the worst, by aiming a beam of light at the eye. When the beam is interrupted by cloudiness in the eye, it registers on the scale. In most cases, use of the opacity lensmeter is combined with the traditional slit lamp to achieve both an objective and subjective diagnosis of cataracts.

• **Endometrial ablation.** In the field of obstetrics/gynecology, argon lasers are now being used to treat endometrial ablation, or prolonged bleeding during menstrual periods. Instead of performing D&Cs, physicians can now use an argon laser, which can help cut down on the number of hysterectomies.

• **Photodynamic therapy.** This treatment, says Dr. McCaughan, is still in the experimental stages, with 40 medical facilities in the U.S. — including Grant — participating in a nationwide study. During the treatment, which is used to treat cancer, "a drug is injected into the vein and (the drug) moves out to all the cells," says Dr. McCaughan, "but it moves out of the normal cells and stays in the cancerous cells."

When tumors are exposed to light from a laser, photosensitizing agents in the dye are activated, which destroys the tumor. The therapy, adds Dr. McCaughan, has been around for about three years and is especially useful in combating cancer in the lungs, esophagus and bladder.

• **Laserthermia.** This therapy, says Stephen Joffe, MD, of Laser Centers of America in Cincinnati, involves heating a tumor until it's destroyed.

• **Ectopic pregnancies.** Using a laser to treat an ectopic pregnancy, Dr. Joffe says, allows the patient to leave the hospital the same day the surgery is performed, as opposed to the conventional three- to four-day stay.

• **Corneal resculpturing.** Though not yet available, corneal resculpturing may soon give physicians the ability to do just what its name implies — resculpture the cornea in order to restore or improve patients' vision.
— *Michelle J. Carlson*

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OSMA Shines in AMA Outreach Program

Membership Recruitment That Works

By Katherine E. Wisse,
Director, Department of Membership Development

Each year the American Medical Association and the OSMA conduct physician outreach membership recruitment programs. Delegates and alternate delegates of both groups participate in the effort.

The AMA Outreach Award winners were recognized at its June Annual Meeting in Chicago. In all, 219 AMA delegates and alternate delegates recruited a total of 541 new AMA members.

Ohio recruited 47 new members and was one of five states that received an outstanding achievement award. Donavin A. Baumgartner, Jr., MD, Cleveland, immediate past president of the OSMA, member of the Ohio Delegation, and one of OSMA's strongest advocates of membership, accepted the award for Ohio.

Other members of the Ohio delegation who received individual awards were:

Theodore J. Castele, MD, Cleveland
Owen E. Johnson, MD, Columbus
Edmund C. Casey, MD, Cincinnati
S. Baird Pfahl, MD, Sandusky.

These AMA award winners were asked why they believe in membership recruitment. Dr. Baumgartner, who has won individual Outreach Awards at both AMA and OSMA each year since the programs were implemented, said that "Membership perhaps is the most important issue now not only because it provides us with the funds necessary to pursue the vital issues of the organization, but also because it is essential that we have a significant majority of physicians represented in organized medicine."

Dr. Castele, former OSMA Councilor and Chairman of the Ohio delegation to AMA put it this way:

"Membership recruitment is crucial to any organization because it is the way of sustaining the lifeblood of the organization. The members are the lifeblood, not only because of their dues, but, more importantly, we need them personally to become involved and be part of the actions and functions of the organization. Right now we are at a crucial juncture. With societal forces having such a huge impact on medical practice, we must strive harder to be alert in order to protect our patients' interests."

Dr. Johnson, president of the Academy of Medicine of Columbus and Franklin County and member of the Ohio delegation to the AMA said: "The simplest way to meet financial objectives and goals is to increase membership. The overall support of membership by central Ohio physicians is excellent but it can be improved. Medicine in general faces new concerns that we all

Donavin A. Baumgartner, Jr., MD

". . . it is essential that we have a significant majority of physicians represented in organized medicine."

Theodore J. Castele, MD

"The members are the lifeblood . . . we need them to become involved and be part of the action . . ."

Owen E. Johnson, MD

"Medicine faces new concerns we all must face head on. All physicians, united in organized medicine, can meet the challenge."

must face head on if we are to preserve the greatest health-care system in the world in some facsimile of what it has been in the past. All physicians united in organized medicine can meet this challenge, and that's why membership recruitment is so important."

Dr. Casey, past president of the Academy of Medicine of Cincinnati and current chairman of its Judicial Committee, said:

"It is important particularly for older physicians to go after young ones because they do not understand the importance of AMA membership. What I did was write to them personally saying to them that whether you are a member or not, I am there at the AMA to develop policy. I would feel much better if you were a member so your voice could be heard."

Dr. Pfahl, Sandusky, past president of the OSMA and member of the Ohio delegation to the AMA, said:

"The important thing as far as AMA membership is concerned that when everyone is taking shots at us at the national and state levels, including limited practitioners, it is vital that we have a strong, unified national organization, and the AMA is the only one that meets that criteria."

The AMA awards received by these winners included an Outreach tie tack, tie, sweater or blazer, depending upon the number of new members who joined as result of their efforts.

All of organized medicine, however, has been a winner as a result of this program because organized medicine itself has been strengthened by the increased

Edmund C. Casey, MD

S. Baird Pfahl, MD

". . . I would feel much better if you were a member so your voice could be heard."

"It is vital we have a strong, unified national organization."

membership. OSMA, too, has an Outreach program in which over 72 OSMA delegates and alternate delegates have agreed to participate.

You can be a part of this program if you are responsible for one or more active members joining your county society and the OSMA. Your reasons might echo those of the AMA award winners, but in addition to increasing county and OSMA strength in numbers and its voice in representing the doctors of Ohio, you will be a winner also.

If you recruit at least one new member you will earn an OSMA logo watch *and* a chance on a weekend for two at the beautiful Greenbriar in West Virginia.

Do you have a new partner? Is someone on your hospital staff not a member? Is there a new doctor in town? These would be good sources for you to be an Outreach winner too.

Contact the OSMA Department of Membership Development for further details. **OSMA**

Katherine E. Wisse is Director of OSMA's Department of Membership Development.

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OBITUARIES

JAMES A. DEJUTE, MD, Maumee; State University of New York at Buffalo School of Medicine, Buffalo, NY, 1945; age 68; died June 10, 1989; member OSMA.

LOUIS A. GLEITSMAN, MD, Warren; Ohio State University College of Medicine, 1943; age 77; died June 16, 1989; member OSMA and AMA.

CLARENCE CECIL JACKSON, MD, Naples, FL; Jefferson Medical College of Thomas Jefferson University, Philadelphia, PA, 1928; age 84; died June 12, 1989; member OSMA and AMA.

C. ERIC JOHNSTON, MD, Columbus; Ohio State University College of Medicine, 1943; age 70; died June 18, 1989; member OSMA and AMA.

WARREN P. KILWAY, SR., MD, Akron; Case Western Reserve University School of Medicine, 1922; age 92; died July 7, 1989; member OSMA and AMA.

WILLIAM J. RALSTON, MD, Lorain; Temple University School of Medicine, Philadelphia, PA, 1939; age 76; died June 22, 1989; member OSMA and AMA.

ALFRED E. RHODEN, MD, Port Clinton; Universitaet Wien, Medizinische Fakultaet, Wien, Austria, 1936; age 77; died June 17, 1989; member OSMA and AMA.

DAVID S. SCHWAB, MD, Clearwater, FL; Tufts University School of Medicine, Boston, MA, 1962; age 51; died June 8, 1989; member OSMA.

ELSIE K. SNELL, MD, Amherst; New York Medical College, New York, NY, 1933; age 81; died June 17, 1989; member OSMA and AMA.

M. PAUL THOMAS, MD, Cleveland; Hahnemann Medical College of Philadelphia, PA, 1935; age 80; died June 28, 1989; member OSMA and AMA.

JAMES F. WHITACRE, MD, Toledo; Eclectic Medical College, Cincinnati, OH, 1927; age 86; died May 25, 1989; member OSMA and AMA.

The Loss Awareness Bulletin is provided each month through the OSMA Task Force on Professional Liability and its subcommittee on Loss Awareness.

Reducing the Risk of Liability With the Help of Hospital Staff

Key areas of malpractice risk reduction — focusing on the physician and office procedure — become key factors in the hospital setting as well.

Concerns such as communication, physician-patient rapport, physician-staff contact, medical records and follow-up are equally significant in limiting the risk of liability in the hospital.

Good rapport between the physician and the hospital staff are essential in maintaining good care of the hospitalized patient. At the same time, this cooperation provides the doctor with an added degree of assistance which could make a difference in dealing with a patient who may be contemplating legal action.

Hospital staff who have been misused or verbally abused often retaliate in some manner — if not directly in communication with the patient, perhaps later during a deposition related to a malpractice claim. There have been numerous instances recently in which hospital or nursing staff attempted to "get even" with doctors through testimony on the witness stand — doctors who repeatedly mistreated hospital staff.

Need for Interaction

When staff feels appreciated, they generally will use every opportunity available to protect and promote the physician in the patient's eyes. Conversely, ordering the staff around in an abrupt and highly unpleasant manner often diminishes respect for the physician from the patient. If staff does not like the physician, they still may provide good professional care and treat the physician courteously — but that extra measure of concern, reflected when staff is attached to a physician, will not exist.

Conversations with hospital staff frequently reveal the ill effects of disciplining or harshly criticizing hospital nursing staff in front of the patient. Frequently, patients will side with the person being disciplined and will grow to resent the physician for his actions. The hospital staff serves the patient's needs for 24 hours a day; the physician is available to see the patient for far shorter periods of time.

Potential Pitfalls

For obvious reasons, rapport and good communication between doctor and nursing staff become vital. Consider the potential for liability which could arise from either of these situations:

Monitor strips begin to show abnormalities at 2 a.m. Nursing staff does not call the physician until after 6 a.m. Why?

- Dr. X will become angry or verbally abusive if phoned in the middle of the night, so staff holds off and hopes patient will get better.
- Dr. X will not come to the hospital, but will say that the patient "sounds fine." Dr. X also is known for asking staff "Why don't you learn your business?" and makes them feel incompetent.

Repeated occurrences of this

Deterring the risk of a professional liability claim can involve complex medical, as well as non-medical, issues.

could set the stage for disaster.

Difficult Litigation

Among the more difficult malpractice cases to defend is a situation where the nurse's record shows progressive or serial deterioration of the patient's condition while the doctor's progress notes continue to say "doing well." Two suggested actions:

- At every visit, review the nurse's record and note any changes from the previous visit.
- If appropriate, incorporate a reference to the nursing notes into your progress notes. For example: "Fluctuation in temperature over past 24 hours does not appear to indicate infection; post-op wound is not inflamed. If patient's temperature exceeds 102, nursing staff is instructed to call me."

Malpractice case records also show instances where nursing notes indicated that the physician did not or refused to believe the seriousness of the patient's condition as related by the nurse . . . and the patient died.

Similarly, case files also show examples of physicians who refused to come for an evaluation of the patient or failed to transfer the patient to a higher level of care, such as ICU. This presents significant risk should the patient suffer permanent damage which could have been averted had more intensive care been rendered.

Additional Suggestions

- Have hospital nursing staff give a verbal account of the patient's status during your rounds.
- Verify that verbal orders are written in the chart (not just the cardex); have staff repeat back your verbal phone instructions to ensure accuracy.
- Try to avoid placing nursing staff in the position of diagnosing the patient's condition or deciding on treatment if you have not seen the patient.
- Provide nursing staff with all key information regarding patient medication (drug, route, site and dosage).
- Notify the nursing supervisor promptly if you discover that the staff have not noted changes in patient condition or have not given verbal notification of changes. Similarly, notify the supervisor if nursing staff have failed to either record or to carry out your orders.

Deterring the risk of a professional liability claim can involve complex medical, as well as non-medical, issues. Cooperation between the hospital nursing staff and physicians — while maintaining good communication and adequate medical records — will involve considerable effort. Yet any successful defense of a malpractice claim could depend heavily on the success of these actions. **OSMA**

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OSMA-MSS Planning Growth in 1989-90

By Cindy J. Smith

We are very excited by the opportunities and challenges the Ohio State Medical Association Medical Student Section is facing in 1989-90. The officers this year are fortunate to have not only our personal resources but also dynamic delegates from each medical school and over 30 students who have received appointments to OSMA physician committees.

Our Ohio student group is growing in stature in the national medical student section. Last year, Cindy Smith was Editor-in-Chief of *Pulse,* the national medical student magazine published in *JAMA*. Mary Riess was the Region 5 representative to the states' Leadership Steering Committee in the AMA-MSS. We had two Ohio students serving on committees at the AMA-MSS annual meeting: Andre Hall, UC, served on the Rules Committee and Michael Lucherini, also from UC; served on a reference committee. Two Ohio students ranked second for AMA committee positions available to students nationally. This year, on June 18, Ohio's medical student section clearly established itself as a national force with the election of Mary Riess, OSU, to AMA-MSS's governing council, the five-person ruling body of the AMA-MSS. In December Audrey Ludwig, who has served on Ohio's AMA delegation as the student alternate delegate for two years, will run as a candidate for the coveted student slot on the AMA-BOT.

Ohio's student resolutions have led to changes. We have had several resolutions in the past three years that have eventually been passed by the AMA. This year we will continue to introduce resolutions toward meeting the goal of a smoke-free society by the year 2000 and toward improving adolescent health in Ohio. We have a new student committee on legislation and resolutions whose goals are to better inform students on legislative issues and develop a student political action network so that we can respond quickly to the legislative concerns of the OSMA and Ohio medical students, and to help the OSMA-MSS in resolution development.

We are working hard on chapter development. Several chapters have very active student-to-student programs which the OSMA-MSS wants to further develop and nurture. Additionally, we are developing a statewide lecture program with varied and interesting topics presented by scholars of national stature. The MSS is looking for inventive recruiting techniques to attract medical students with broad interests and convince them that organized medicine is both important and interesting. To achieve this goal, we plan on greatly expanding our Ohio Medical Student Research Forum.

We want to work more closely with physicians on several issues this year and are optimistic that the student appointments to physician committees will promote some tighter collaboration. We are especially interested in further developing our student-to-student program and in developing an effective student political action group.

continued on page 743

OSMA-MSS Officers

Cindy J. Smith, WSU, President of the OSMA-MSS
Robert Mott, WSU, Vice President, OSMA-MSS
Larry Frick, UC, Secretary, OSMA-MSS
Audrey Ludwig, UC, Alternate Delegate to the AMA

COUNTY COLLECTION

Medical society demands creek cleanup

It's been 16 years since the Nease Chemical Plant shut down its operations northwest of Salem, Ohio, but the by-products of those years still flow through town.

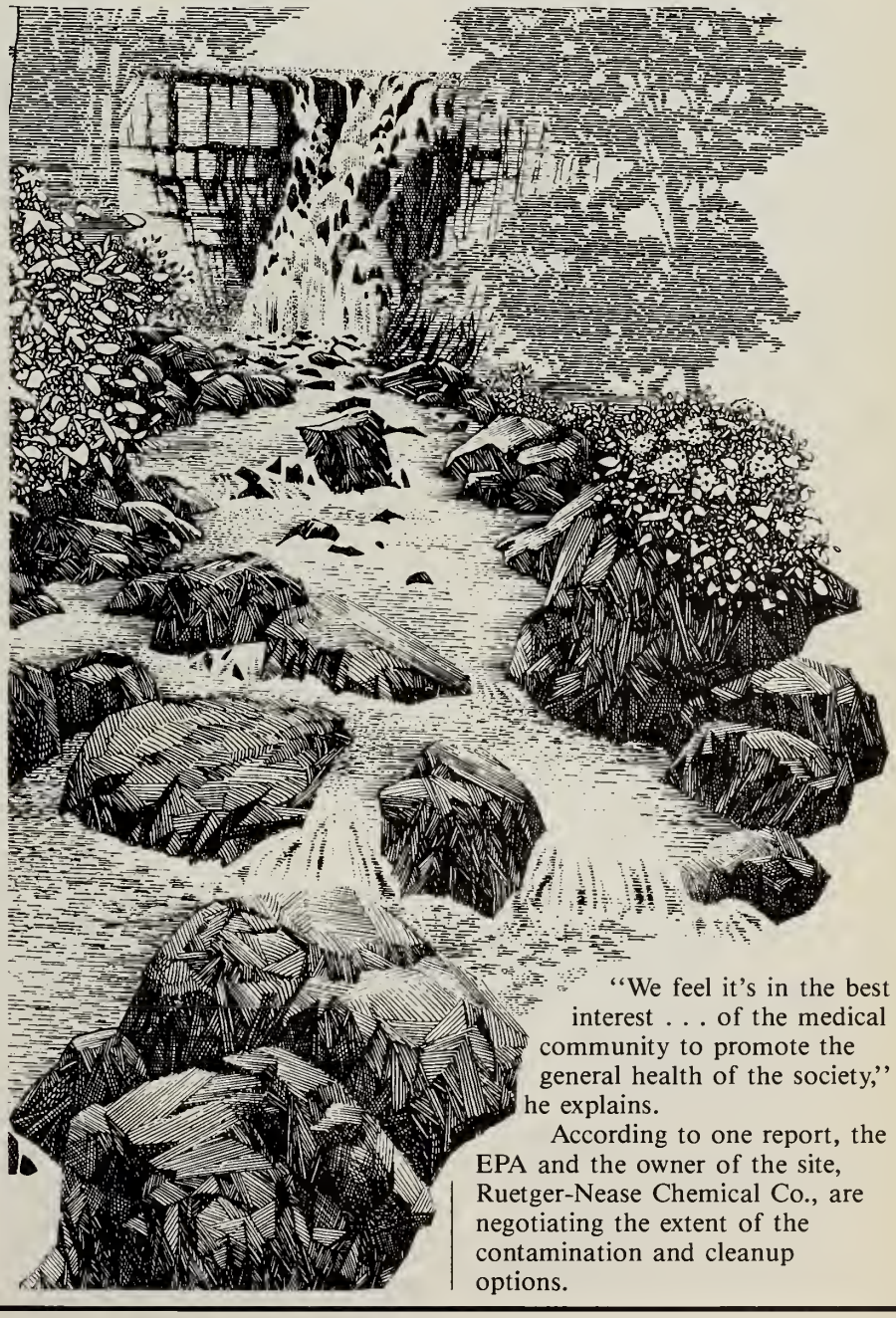
The plant halted production in 1973 after state officials determined that plant chemicals were contaminating an area of Little Beaver Creek.

The EPA waited another 10 years before including the plant and the creek on its federal Superfund list, which comprises the nation's worst contamination sites.

Now, another six years later, Little Beaver Creek still contains "a poisonous morass of chemicals," says Salem surgeon Michael Schmidt, MD — a situation he finds inexcusable.

"It's been a sad tale of neglect and irresponsibility," he says — one that could have been prevented with a responsible cleanup. But as it turns out, a clean-up date for the Little Beaver Creek was put on the back burner, while the problem itself has been left to smolder.

Dr. Schmidt is one of three members of an Environmental Committee created by the Columbiana County Medical Society to accelerate the cleanup of what he describes as a "tremendous toxic hazard."



"We feel it's in the best interest . . . of the medical community to promote the general health of the society," he explains.

According to one report, the EPA and the owner of the site, Ruetger-Nease Chemical Co., are negotiating the extent of the contamination and cleanup options.

County Collection . . .

Medical society demands creek cleanup . . . *continued*

In the meantime, the Ohio Department of Health has warned citizens in the area to avoid using the creek for swimming, fishing or drinking water. Thus, for most practical purposes, Little Beaver Creek has been rendered unusable.

"One of the greatest threats to health care can be the environment," Dr. Schmidt points out. When physicians visit Third World countries to provide health care, one of the first things that needs to be done is to clean up the immediate environment — to ensure there's sanitary waste disposal and clean water, for example. Otherwise, he continues, the environment would constantly be reinfecting the patients.

"In many ways, we've (the medical profession) concentrated on sophisticated technology — which is good," he says, "but we're missing some basic issues. The foundation of health in the U.S. is a safe environment."

The committee has concentrated much of its initial efforts on a letter-writing campaign to attract the attention and support of federal and state legislators. The only response thus far has been the proverbial form letter, but the committee plans to keep plugging away.

The members plan to meet again in September. By then, Dr. Schmidt hopes to have a patient education brochure in the works that asks citizens to avoid the contaminated area of the creek and to write to their legislators demanding action.

But until cleanup efforts are under way, "Chemicals (in the creek) will persist indefinitely," Dr. Schmidt points out. "It's safe to assume that people have been injured (by the contamination), but proving it is very difficult."

Because Ohio is one of the nation's most industrialized states, the medical community should regard the environment as one of its major issues, Dr. Schmidt suggests. "We (physicians) need to show people that we care."

Although he hesitates to use the word "accountability" — noting that it's a word that's often overused — Dr. Schmidt says that's exactly what the Columbiana County Medical Society, the citizens of Salem and Little Beaver Creek are waiting for . . . and, he says, that's what they deserve. — *Deborah Athy*

> ***". . . we're missing some basic issues. The foundation of health in the U.S. is a safe environment."***

Cleveland expanding AIDS Project

An AIDS newsletter and handbook containing up-to-date information on AIDS are two of the latest additions to the Academy of Medicine of Cleveland's AIDS Project.

Shirlee Leathers, public relations director for the Academy, says that both will contain "the kinds of things that practicing physicians need to know . . . anything that would help them deal with patients who have AIDS, patients who have questions about AIDS, patients who want to be tested . . ."

The newsletter, which will be published three or four times a year, according to Leathers, will include information about the activities of the Cleveland AIDS Clinical Trials Unit (ACTU). The ACTU, University Hospitals' nationally recognized AIDS referral center, is conducting experimental treatments for HIV infection. The newsletter will not only update Academy physicians about the center's progress, but will tell physicians how to refer their patients.

The Academy is also working with ACTU to produce a handbook that will give physicians practical guidelines for dealing with HIV infection and AIDS.

"(The handbook) will be the kind of thing they'll set on their shelf," says Leathers. "It's not the type of thing you read in one sitting . . . It'll be a resource book."

The handbook will provide concise guidelines for managing HIV and AIDS, while a resource section will explain to physicians where to refer patients for medical, social and psychological support. The manual will also outline legal guidelines for case definition and reporting.

The handbook, which is expected to be distributed sometime in late 1989 or early '90, will be contained in a three-ring notebook so as to allow for periodic updates.

The Academy first established the AIDS Project in 1987 in order to update northeastern Ohio physicians on HIV infection and AIDS without duplicating national efforts. Its first project, a video entitled "The Physician's Role in the AIDS Epidemic," met with wide success and to date has been seen by 1,200 health-care workers. The Academy has since developed CME courses on AIDS and a poster on AIDS.

Leathers says the introduction of these two new projects only further illustrates the Academy's dedication to keeping its members informed about the AIDS epidemic. — *Michelle J. Carlson*

What's New in Your County?

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Call or write: OHIO Medicine, 1500 Lake Shore Dr., Columbus, Ohio 43204-3824, (614) 486-2401.

PROMOTE AIDS EDUCATION

AMA MEDICAL STUDENT SECTION T-SHIRT SALE

Wear the t-shirt that promotes AIDS education. The t-shirts' slogan "**Spread the Word, Not the Disease** - AIDS" reflects the Medical Student Section's ongoing commitment to AIDS education. The Section sponsors a community action program "AIDS Education: Medical Students Respond" through which medical students help educate adolescents about AIDS.

The t-shirts are bright red and are available in sizes large and extra large.

Please enclose a $10.00 donation (per shirt) to the AMA-MSS/AMA-ERF International Scholars Fund. Price includes postage and handling. All proceeds will benefit the Scholars Fund.

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at WSUSOM, will lead this fascinating discussion on "Can the law solve our social problems or does it create them?"

The participants in the Fall Confluence will come together for the concluding plenary session, which deals with our sexuality in the middle years. Elaine Koenigsberg, MSW, will lead the discussion on this most personal and fascinating topic.

You won't want to miss the 1989 Fall Confluence. Bring a friend and split up the workshops so you will have the benefit of having attended all four. The date is Friday, October 13, 1989, 8:00 a.m.-3:00 p.m. Wright State University, Colonel Glenn Highway, on Route 675 south of I-70 and north of I-35. Lodging for the Confluence is the Holiday Inn across the street from Wright State University. Registration fee for the Fall Confluence is $50 per person (excluding hotel). For information call: Sally Graubarth (513) 433-1911 or Sara Rich (513) 434-6669.

Next month in OHIO Medicine

- **Report of AMA Activities . . .** including photos of the AMA's recognition of Hart Page.
- **Private Judging . . .** a shot in the arm for Ohio's malpractice-weary physicians?

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Head Injury Recovery Center at Clifton
625 Probasco, Cincinnati, Ohio 45220

Proceedings of the Council

Stouffer Center Plaza Hotel, Dayton
May 5, 1989

A regular meeting of the Council of the Ohio State Medical Association was held Friday, May 5, 1989 at the Stouffer Center Plaza Hotel, Dayton.

Those present were:
Donavin A. Baumgartner, Jr., M.D., President
William J. Marshall, M.D., Dayton
D. Ross Irons, M.D., Bellevue
Joseph Sudimack, Jr., M.D., Columbus
Stanley J. Lucas, M.D., Cincinnati
William H. Kose, M.D., Findlay
Walter A. Reiling, Jr., M.D., Dayton
John A. Devany, M.D., Toledo
Henry G. Krueger, M.D., North Olmsted
J. James Anderson, M.D., Youngstown
Nermin D. Lavapies, M.D., Martins Ferry
John F. Kroner, Jr., M.D., Athens
Richard Villarreal, M.D., Wheelersburg
H. William Porterfield, M.D., Columbus
Charles G. Adams, M.D., Vermilion
Jack L. Summers, M.D., Akron
Richard Steinman, President, MSS, Sylvania
Thomas F. Helmsworth, M.D., Chm., Resident Physicians Section
Edmund W. Jones, M.D., Hospital Medical Staff Section, Cincinnati
Theodore J. Castele, M.D., Chm., AMA Delegation, Cleveland
Ray W. Gifford, Jr., M.D., AMA Board of Trustees, Cleveland
Catherine Staton, President, OSMA Auxiliary, Springfield
William Todd, Porter Wright, Columbus
John Kasper, AMA, Chicago
Rick Ayish, President, Ohio Capitol Policy Consultants, Inc.
Carolyn Towner, Vice President, Ohio Capitol Policy Consultants, Inc.

Those present from OSMA staff:
Herbert E. Gillen
D. Brent Mulgrew, Esq.
Robert D. Clinger
Katherine E. Wisse
Gail E. Dodson
Carol W. Mullinax
Deborah Bahnsen, Esq.
William E. Fry
Kent Studebaker
Doug Graff, Esq.
John Van Doorn
Cynthia Snyder, Esq.
Doug Evans
Margaret High-Thomas
Jim Wile
Karen Edwards

President's Remarks

Dr. Baumgartner reported on a meeting he and staff had with representatives of the Ohio PRO regarding problems that physicians have been experiencing with that agency. Dr. Baumgartner expressed the opinion that the meeting was worthwhile and that perhaps communications to Ohio physicians will be more appropriate and timely.

Dr. Baumgartner called for nominations to be forwarded to the OMPAC Board for its consideration to fill vacancies from the Fifth and Ninth Councilor Districts. The Council voted to nominate Daniel Van Heeckeren, M.D., Cleveland for the Fifth District vacancy and Robert White, M.D., Portsmouth for the Ninth District vacancy.

Dr. Baumgartner paid tribute to Dr. Irons, Dr. Cannon and Richard Steinman who are all retiring from the Council after this meeting. Special thanks was given to Mrs. Catherine Staton for her leadership of the Ohio State Medical Association Auxiliary this past year.

Dr. Baumgartner gave special recognition to the three Councilors who are all candidates for the office of OSMA President-Elect. He thanked each of them for their contributions to organized medicine.

Dr. Irons commended Dr. Baumgartner for his excellent leadership of the Association this past year.

Previous Minutes

Minutes of the March 18, 1989 meeting of the Council were approved as distributed.

Legislative Report

Mr. Van Doorn and Ms. Snyder presented the recommended actions

on bills pending before the legislature as taken by the Committee on State Legislation at its meetings on March 30 and April 19, 1989.

The Council adopted the recommended action on proposed legislation as follows:

House Bill 222 (State Representative Ross A. Boggs, Jr., D-Andover) Workers' Compensation System — Restructure the Workers' Compensation system.

ACTION: ACTIVE OPPOSITION

Senate Bill 104 (State Senator Robert W. Nye, R-Barnesville) Optometry — Expands the scope of optometry to include prescribing drugs used in the treatment of the visual system. The bill also would allow optometrists to perform eye surgery.

ACTION: ACTIVE OPPOSITION

House Bill 227 (State Representative Ray Miller, D-Columbus) — Authorizes physical therapists to accept patients referred by chiropractors.

ACTION: ACTIVE OPPOSITION

House Bill 268 (State Representative Ray Miller, D-Columbus) — Psychologists' Hospital Staff Privileges — Prohibits discrimination against psychologists by hospitals in granting staff membership or professional privileges.

ACTION: ACTIVE OPPOSITION

House Bill 257 (State Representative Paul H. Jones, D-Ravenna) — Medicaid — Creates the Joint Legislative Committee on Medicaid Oversight.

ACTION: SUPPORT

Senate Bill 80 (State Senator Richard P. Schafrath, R-Loudonville) — License Athletic Trainers — Provides for the licensing of athletic trainers.

ACTION: NO POSITION WITH TECHNICAL ASSISTANCE

House Bill 354 (State Representative Vermel Whalen, D-Cleveland) — Immunity for Physicians Reported on Transport Workers — Confers qualified immunity from civil liability upon physicians who inform employers engaged in business of public transportation about the use of controlled substances by their employees.

ACTION: SUPPORT WITH TECHNICAL ASSISTANCE

House Bill 319 (State Representative Marc Guthrie, D-Newark) — License Emergency Medical Services — Would give local governments the option of allowing the new Ohio Ambulance Licensing Board, which is created within the existing Ohio Emergency Medical Service Agency, to license emergency medical services.

ACTION: SUPPORT

House Bill 332 (State Representative Paul H. Jones, D-Ravenna) — Certificate of Need Program — Would re-establish the Ohio Certificate of Need Program, for two years, which was set to expire on June 30, 1989, governing major expenditures for delivery of health services.

ACTION: THE COUNCIL VOTED TO LOOK INTO THE RESTRICTIVE MANDATES IN THE LAW AND RULES AND PROVIDE TECHNICAL ASSISTANCE IN OPPOSING THOSE MANDATES

House Bill 317 (State Representative Ray Miller, D-Columbus) — Recovery Services — Establishes the Department of Recovery Services to administer drug and alcohol abuse treatment programs.

ACTION: NO POSITION

House Bill 260 (State Representative Jane Campbell, D-Cleveland) — Human Growth Curriculum — Would require schools to implement a course in "human growth and development" and would require state agencies to provide teen-agers with information about paternity and child support.

ACTION: ACTIVE SUPPORT

The Council approved the concept of recommending that the Ohio State Medical Board hire a full-time medical consultant to direct the investigative resources of the Board.

Mr. Ayish provided the Council with an update on the current status of S.B. 2, the Omnibus AIDS legislation, and reported this bill would be voted out of the Senate the week following the Annual Meeting.

Ms. Towner reported that thanks to efforts of the OSMA the governor has chosen to opt out of the federal infectious waste disposal mandates. It was pointed out this action will save many physicians significant costs by their not having to comply with the onerous federal mandates.

The legislative staff also gave status reports on bills pending before the legislature for which positions have already been established by the Council.

Auditing and Appropriations Committee

Dr. Anderson presented the minutes of the May 4, 1989 meeting of the Committee on Auditing and Appropriations. He also commented on the activities of the Committee for the past 12 months.

Dr. Baumgartner thanked Dr. Anderson for his efforts on behalf of the Council in serving as chairman of this very active Committee.

The treasurer's report was presented by Dr. Sudimack and was approved as distributed.

Annual Meeting Update

Mrs. Dodson reported on the arrangements for the Annual Meeting and answered questions about the schedule of events.

AMA Update

Dr. Gifford reported problems are developing with specialty societies in remaining united on the issue of the RBRVS and stressed the importance of all medical groups pulling together. Dr. Gifford also discussed in detail problems with the Canadian health-care system.

Dr. Castele reported that plans for the Delegation's activities at the June AMA Annual Meeting are well under way including the campaign to get Dr. Porterfield elected to the AMA Council on Medical Services.

Dr. Castele invited Council members to attend the AMA Delegation meeting that will be held later in the day.

Committee Reports for Information

Minutes of the following committees were received and filed:

Committee on Accreditation, April 3, 1989

OSMA Infectious Disease Committee, April 10, 1989

Committee on Education, April 12, 1989

Task Force on Health Insurance Issues, April 19, 1989

Committee Reports for Action

Committee on Cancer — March 17, 1989 — On recommendation of the Committee the Council approved sending letters to county medical societies offering support for the school health education campaign ("Your Health Report Card" and "Obey These Signals") sponsored by the American Cancer Society, Ohio Division, Inc.

A second recommendation of the Committee was returned for further consideration.

Committee on Membership — April 14, 1989 — The Council approved the recommendation of the Committee that a pilot study for spousal dues reduction be conducted in Franklin and Hamilton counties in 1990 with OSMA dues set at 75% of the active rate for each member of the physician couple ($296.25 in 1990) with the program to be evaluated next year.

Legal Report

Mr. Mulgrew reported that the OSMA has filed an amicus brief in a lawsuit against HCFA's policy of considering the filing of a laboratory claim on a non-assigned basis an offense justifying the imposition of a sanction by Medicare.

The government has filed a motion to dismiss the lawsuit arguing a lack of jurisdiction by the court. The OSMA brief argues that the federal court has the jurisdiction to consider the claim and grant the injunction requested against the third-party intermediary and Medicare.

Mr. Mulgrew and Mr. Graff presented the final draft of the Ohio Model Medical Staff Bylaws and encouraged all members of Council to attend the OSMA-HMSS program describing the new Model Bylaws in detail.

Proposed amendments to the Richland County Bylaws were approved.

New Business

Dr. Summers presented and discussed Summit County Medical Society's request for OSMA's endorsement and financial support for its proposed court action to stop police monitoring of prescriptions in Akron pharmacies. The Council voted to support the SCMS's proposed action and will consider financial support when a specific request is made.

The Council heard a report on the new developments in *Wilson V. Burt et.al.* Dr. Baumgartner appointed an ad hoc committee of Dr. Lucas and Dr. Krueger to keep the Council appraised of developments in this entire matter.

Meeting adjourned.

Respectfully submitted,
Herbert E. Gillen
Executive Director

Stouffer Center Plaza Hotel, Dayton May 8, 1989

A regular meeting of the Council of the Ohio State Medical Association was held Monday, May 8, 1989 at the Stouffer Center Plaza Hotel, Dayton.

Those present were:

William J. Marshall, M.D., Dayton, President
Donavin A. Baumgartner, Jr., M.D., Cleveland
John A. Devany, M.D., Toledo
Joseph Sudimack, Jr., M.D., Columbus
Stanley J. Lucas, M.D., Cincinnati
Walter A. Reiling, Jr., M.D., Dayton
William H. Kose, M.D., Findlay
Su-Pa Kang, M.D., Toledo
Henry G. Krueger, M.D., North Olmsted
Robert C. Reed, M.D., Alliance
Nermin D. Lavapies, M.D., Martins Ferry
John F. Kroner, Jr., M.D., Athens
Richard Villarreal, M.D., Wheelersburg
Claire V. Wolfe, M.D., Columbus
Charles G. Adams, M.D., Vermilion
Cindy J. Smith, Dayton, President, Medical Student Section
Theodore J. Castele, M.D., Chm., AMA Delegation, Cleveland
Barbara Marshall, President, OSMA Auxiliary, Dayton

William Todd, Porter Wright, Columbus
Rick Ayish, President, Ohio Capitol Policy Consultants, Inc.
Those present from OSMA staff:
Herbert E. Gillen
D. Brent Mulgrew, Esq.
Gail E. Dodson
Katherine E. Wisse
Jim Wile
Carol W. Mullinax
Doug Evans
Karen Edwards
Margaret High-Thomas
Deborah Bahnsen, Esq.
Robert D. Clinger
Doug Graff, Esq.
William E. Fry
Kent Studebaker
Cynthia Snyder, Esq.
Kathy Wehe
John Van Doorn

Dr. Marshall commended Dr. Baumgartner for his leadership of the Association during his year as President. Dr. Devany was introduced as the new President-Elect of the Association and was congratulated on his election.

Dr. Marshall introduced and welcomed the new Councilors as follows:
Su-Pa Kang, M.D., Toledo, Fourth District Councilor
Robert C. Reed, M.D., Alliance, Sixth District Councilor
Claire V. Wolfe, M.D., Columbus, Tenth District Councilor
Thomas F. Helmsworth, M.D., Cincinnati, Resident Councilor
Cindy J. Smith, Fairborn, Student Councilor

A schedule of Council meetings for the next 12 months was distributed.

The Council approved Dr. Marshall's proposed committee assignments for the next 12 months.

Dr. Marshall announced that letters have been received nominating Stanley Lucas, M.D. and Joseph Sudimack, M.D. for the office of President-Elect for the 1990 Annual Meeting.

The Council adopted a resolution for presentation to the AMA congratulating and commending C. Everett Koop, M.D. on the occasion of his retirement as the Surgeon General of the United States.

Dr. Marshall expressed, on behalf of Council, special appreciation to Mrs. Dodson and her staff for an excellently organized Annual Meeting. Dr. Marshall also thanked the Councilors for carrying out their responsibilities with the Resolution Committees.

Meeting adjourned.

Respectfully submitted,
Herbert E. Gillen
Executive Director

CENTER FOR CONTINUING MEDICAL EDUCATION *PRESENTS*

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New England Deaconess Hospital
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William J. Darby, M.D., Ph.D.
Vanderbilt University School of Medicine

Robert E. Olson, M.D., Ph.D.
State University of New York School of Medicine

Roslyn Alfin-Slater, Ph.D.
University of California School of Public Health

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Nutrition for Clinical Practice and Everyday Living will feature a special holiday shopping tour for participants and spouses through Columbus' new City Center Mall.

For a conference brochure or more information, please contact The Ohio State University Center for Continuing Medical Education at 614-292-4985 or 1-800-492-4445.

CONTINUING MEDICAL EDUCATION

September

American Medicine: Today and Tomorrow
When: September 15, 1989
Where: Susan H. Edwards Auditorium
Riverside Methodist Hospitals
Columbus, Ohio
Credit: 3.25 hours, Category I
Fee: not specified
Contact: Riverside Medical Education Office
614-261-5468

A Weekend of Medicine
When: September 15-17, 1989
Where: Radisson Harbour Inn
2001 Cleveland Road
Sandusky, Ohio
Credit: 5 hours per day, Cateogry I
Fee: not specified
Sponsor: The Cleveland Clinic Educational Foundation
Contact: Department of Continuing Education, The Cleveland Clinic
9500 Euclid Avenue
Cleveland, Ohio 44106
1-800-762-8172

GI Diagnostic Laboratory: Techniques and Clinical Applications
When: September 20, 1989
Where: Bunts Auditorium, Cleveland Clinic
9500 Euclid Avenue
Cleveland, Ohio 44195
Credit: 6 hours, Category I
Fee: $100, physicians; $75, residents; $50 nurses and GI assistants
Sponsor: The Cleveland Clinic Educational Foundation
Contact: Department of Continuing Education
The Cleveland Clinic,
9500 Euclid Avenue
Cleveland, Ohio 44106
1-800-762-8172

Current Issues in Psychiatry
When: September 23-24, 1989
Where: Salt Fork State Park Lodge
Cambridge, Ohio
Credit: up to 8 hours, Category I
Fee: $115, OPA member ($60 for one day); $130, non-member; $50, resident member
Sponsor: Ohio Psychiatric Association
Contact: Ohio Psychiatric Association
1500 Lake Shore Drive
Columbus, Ohio
43204-3824

Cardiac Rehabilitation: Decreased Risk/Increased Benefit
When: September 28-30, 1989
Where: Bunts Auditorium, The Cleveland Clinic
9500 Euclid Avenue
Cleveland, Ohio 44195
Credit: 15 hours, Category I
Fee: not specified
Sponsor: The Cleveland Clinic Educational Foundation
Contact: Department of Continuing Education
The Cleveland Clinic Educational Foundation
9500 Euclid Avenue
Cleveland, Ohio 44106
1-800-762-8172

October

Pediatrics Today: Update in Neurosciences
When: October 3, 1989
Where: Bolwell Conference Center
University Hospitals
Cleveland, Ohio
Credit: not specified
Fee: not specified
Sponsor: Rainbow Babies and Childrens Hospital, Cleveland, Ohio
Contact: Ellen Spivak
216-844-1509

Dermatopathology Workshop
When: October 7, 1989
Where: The Clinic Center Hotel
East 96th and Carnegie Avenue
Cleveland, Ohio 44106
Credit: 6 hours, Category I
Fee: not specified
Sponsor: The Cleveland Clinic Educational Foundation
Contact: Department of Continuing Education
The Cleveland Clinic Educational Foundation
9500 Euclid Avenue
Cleveland, Ohio 44106
1-800-762-8172

Nephrology Update 1989
When: October 11-13, 1989
Where: Bunts Auditorium
Cleveland Clinic
9500 Euclid Avenue
Cleveland, Ohio 44195
Credit: 18 hours, Category I
Fee: not specified
Sponsor: The Cleveland Clinic Educational Foundation
Contact: Department of Continuing Education
The Cleveland Clinic Educational Foundation
9500 Euclid Avenue
Cleveland, Ohio 44106
1-800-762-8172

Working with Families of Young Children
When: October 12-13, 1989
Where: Park Synagogue
Cleveland, Ohio
Credit: not specified
Fee: not specified
Sponsor: Rainbow Babies and Childrens Hospital, Cleveland, Ohio
Contact: Ellen Spivak, 216-844-1509

Geriatric Medicine: Practical Management of Common Problems
When: October 13-14, 1989
Where: Salt Fork State Park Lodge
Cambridge, Ohio
Credit: not specified
Fee: not specified
Sponsor: Ohio Board of Regents Geriatric Medicine/ Gerontology Education Advisory Committee
Contact: 216-325-2511, ext. 583

Pursuit of Excellence in Practice
When: October 18-19, 1989
Where: Fawcett Center for Tomorrow
Columbus, Ohio
Credit: not specified
Fee: not specified
Sponsor: Central Ohio Diabetes Association
Contact: Lisa Byrnes, Central Ohio Diabetes Association
1803 W. Fifth Avenue
Columbus, Ohio 43212
1-800-422-7946

Interventional Cardiology
When: October 19-20, 1989
Where: Bunts Auditorium
Cleveland Clinic
9500 Euclid Avenue
Cleveland, Ohio 44195
Credit: 12 hours, Category I
Fee: not specified
Sponsor: The Cleveland Clinic Educational Foundation
Contact: Department of Continuing Education
The Cleveland Clinic Educational Foundation
9500 Euclid Avenue
Cleveland, Ohio 44106
1-800-762-8172

Hands-on Assessment and Treatment of Common Foot Problems
When: October 25-26, 1989
Where: The Clinic Center Hotel
East 96th and Carnegie Avenue
Cleveland, Ohio
Credit: 12 hours, Category I
Fee: not specified
Sponsor: The Cleveland Clinic Educational Foundation
Contact: Department of Continuing Education
The Cleveland Clinic Educational Foundation
9500 Euclid Avenue
Cleveland, Ohio 44106
1-800-762-8172

Stress and Health Among the Elderly
When: October 26-27, 1989
Where: Cleveland, Ohio
Credit: not specified
Fee: not specified
Sponsor: Center on Aging and Health, Case Western Reserve University
Contact: May L. Wykle, Director
University Center on Aging and Health
Case Western Reserve University
Cleveland, Ohio 44106
216-368-2692

Androgen Excess Syndrome
When: October 27, 1989
Where: Bunts Auditorium
Cleveland Clinic
9500 Euclid Avenue
Cleveland, Ohio
Credit: 6 hours, Category I
Fee: not specified
Sponsor: The Cleveland Clinic Educational Foundation
Contact: Department of Continuing Education
The Cleveland Clinic Educational Foundation
9500 Euclid Avenue
Cleveland, Ohio 44106
1-800-762-8172

DUNHAM HOSPITAL: ITS BIRTH, LIFE AND DEMISE

Virgil A. Plessinger, MD
Paul N. Jolly, MD
Robert J. Ritterhoff, MD
Helen A. Ackerman, MD

In 1819 Dr. Daniel Drake, the "Father of Medicine" in Cincinnati, secured a charter for the Medical College of Ohio and, the school started in 1820 with 24 students and four faculty members. The philosophy of Dr. Drake, later paraphrased by Sir William Osler, stated: "The school, which is not based on a hospital, may have learned and able professors, but the results of their teaching can never be satisfactory to the student who seeks to make himself a good, practical physician and surgeon." As a result of his efforts, The Cincinnati Commercial Hospital and Lunatic Asylum was opened in 1821 on four acres of land at 12th Street and Central Avenue near the bend of the Erie Barge Canal. Prompt overcrowding led to a gradual expansion eastward toward the canal, now the path of Central Parkway. For many years a picture of this hospital hung in the lobby of the College of Medicine, and beneath it was a legend that read, in part: "It is believed to have been the first public hospital in the nation whose charter gave clinical teaching rights to a specific medical college, Drake's newly founded Medical College of Ohio. In return, the college faculty agreed to care for the poor."

It served as an infirmary, poor house, insane asylum and orphanage as well as a hospital. In 1833 the Cincinnati Orphan Asylum was established, removing one function. The infirmary was moved to other quarters in 1852 and later became The Chronic Disease Hospital, now The Daniel Drake Memorial Hospital. In 1854 the Ames Mansion in the village of Lick Run was leased to accommodate the insane, and it served in this capacity until 1859 when Longview Hospital was erected in Carthage.

The Commercial Hospital of Cincinnati, renamed in 1861, again became overcrowded and, in January of 1869, a new, expanded, 500-bed hospital was opened on the same site as The Cincinnati Hospital. It served the people of this area until 1915 when The Cincinnati General Hospital was constructed on Burnet Avenue.

The roots of Dunham Hospital can be traced to an older series of institutions starting with the first isolation hospital, created after the town council passed an ordinance on March 16, 1816, that it was the duty of the mayor "to prepare a pest-house and cause the removal thereto of all persons afflicted with

Virgil A. Plessinger, MD, former medical director of Dunham Hospital, is retired; Paul N. Jolly, MD, former director of laboratories of Dunham Hospital and Christ Hospital, is retired; Robert J. Ritterhoff, MD, former director of laboratories of Dunham Hospital and St. Elizabeth Hospital (Covington, KY), is retired; and Helen A. Ackerman, MD, former assistant medical director of Dunham Hospital, is a clinician at Hamilton County Tuberculosis Control Center.

smallpox." Evidence suggests it was located on the site of Music Hall. The Isolation Hospital was moved to Lincoln Park in 1840 and in 1863 to Rohs Hill in the Clifton area, a short distance south of the present location of Hughes High School.

In 1878 a 53-acre farm was purchased for use as a smallpox hospital off Guerley Road in the Lick Run Valley north of Price's Hill. Smallpox was then the leading cause of death in Cincinnati, but the disease was quickly controlled by vaccinations, which were initially recommended and later required. With the progressive decline in smallpox, tuberculosis became the leading cause of death with an annual mortality rate per 100,000 averaging about 300 and reaching a peak of 350 in 1881. The few remaining smallpox patients were placed in a refurbished farmhouse on the northern side of the Guerley Road property. The original hospital buildings were remodeled and on July 8, 1897 were dedicated as The Branch Hospital as part of The Cincinnati Hospital, a name retained until 1912. It became the first municipally-owned tuberculosis hospital in the United States as 15 tuberculosis patients were transferred from the city hospital to the 75-bed unit. Dr. Benjamin Lyle was appointed as the physician in charge, a position he retained for most of the next 12 years.

By 1905 the medical staff consisted of the physician in charge and two interns on a rotating basis. In 1909 additional buildings were ready for occupancy, bond issues having raised the $287,000 needed for the expansion.

In 1909 Dr. Kennon Dunham was appointed to the medical staff of the hospital, a position he filled without remuneration for more than 30 years. He had graduated from the Miami Medical College in 1894 and was a pioneer in the field of radiology as well as a highly respected specialist in tuberculosis. He did postgraduate work at Johns Hopkins Hospital in 1896 and later at Great Ormand St. Hospital and St. George Hospital in London in 1899. He was the author of "Stereo-Roentgenography in Pulmonary Tuberculosis" in 1915, describing the modality that would be the main tool for the evaluation and management of tuberculosis and other pulmonary diseases in this area for many decades. Realizing that one must fully know the normal before one could study and understand the abnormal, he continued his research activities at the University of Wisconsin between 1915 and 1917 in collaboration with Dr. William Snow Miller and Dr. Henry Bunting. This group ultimately developed the criteria by which abnormal densities in the roentgenogram could be interpreted in terms of the pathologic changes in the lungs. While at the University of Wisconsin he met another young physician, Dr. John Skavlem, who was also working on the same project. At a later date, at the invitation of Dr. Dunham, Dr. Skavlem joined the office of Dr. Dunham, became a member of the attending medical staff of the hospital, and ultimately followed Dr. Dunham as the medical director. Dr. Dunham was one of the founders of The Ohio Tuberculosis and Health Association in 1901 and later of the local Anti-Tuberculosis League as well as an active member of The National Tuberculosis Association. He was also the president of all three of these organizations as well as the Cincinnati Academy of Medicine.

In 1910, the year in which Dr. C.S. Rockhill succeeded Dr. Lyle as physician-in-charge, Cincinnati recorded a peak of 1,025 deaths due to tuberculosis. It was also the year in which the Cincinnati Board of Education established an "open air" school for the children at The Branch Hospital. In 1912 Dr. Rockwell was appointed the first superintendent as "The Branch" became an independent institution, now renamed The Cincinnati Tuberculosis Sanitorium. In spite of this and two later changes in the official title, the nickname of "The Branch" remained ingrained in the local medical community until 1943 when the name was changed for the last time. Sleeping porches added to existing buildings increased the bed capacity to 300 in 1912. In the following year the Anti-Tuberculosis League of Hamilton County was formed, an organization dedicated to all aspects of the tuberculosis patient — identification, medical treatment, control and rehabilitation. The league lead a successful campaign for the passage of a $350,000 bond issue for construction of ancillary facilities and a preventorium for the care of children who were family contacts of tuberculosis.

When Dr. Rockhill resigned in January of 1914, he opened his own private tuberculosis hospital on Indian Hill to the northeast of Cincinnati. It originally had a capacity of only five patients but it was so successful that it expanded to 60 patients over the next six years. One of the implied virtues of this sanitorium was the alleged altitude of 1,000 feet. High altitude was then considered to be beneficial to the tuberculous patient because of the apparent success of some of the alpine sanatoria in Europe.

On Feb. 1, 1914 Dr. A.C. Bachmeyer was appointed superintendent of The Sanatorium, succeeding Dr. Rockwell. He was also superintendent of The Cincinnati General Hospital, The Chronic Disease Hospital and The Christian R. Holmes Hospital, after it was built in 1928. He was also dean of the College of Medicine from 1925 until 1933.

The decade from 1910 to 1920 showed evidence of great public support for medical facilities with the expansion of The Sanatorium and the construction of The Cincinnati General Hospital, which opened in March 1915, the new College of Medicine in 1916, and a new expanded Good Samaritan Hospital. In addition, there was significant expansion of Bethesda, Christ and Deaconess hospitals.

By 1917 the medical staff of The Branch had been expanded to three full-time physicians and a pathologist who directed the activities of the Percy Shields Memorial Laboratory. Dr. Vera Norton, one of the new resident staff physicians, later became the associate medical director, and served the medical staff of the hospital for 24 years. Students of the College Of Medicine were now receiving clinical experience on a regular basis in physical diagnosis and in the therapy of tuberculosis. According to College of Medicine catalogues of this era: "Students spend from one to two whole days here a week for one semester in their junior year, studying the patients from their reception into the hospital, through wards and laboratories and into the postmortem room if death occurs."

The precise time that Dr. Dunham became the medical director of The Branch is obscured by time. The catalogue for the university for 1921-1922 lists Dr. Bachmeyer as the superintendent and medical director of The Cincinnati General Hospital and The Tuberculosis Hospital, with Dr. Philip Gath as the assist-

ant superintendent of the latter. Dr. Dunham, as a faculty member of the College of Medicine, was the head of the Department of Tuberculosis. In regard to the staff at The Branch Hospital, the director was Dr. Dunham, with Dr. Norton as assistant director and resident physician. The resident pathologist was Dr. J.B. Rogers and another resident physician was Dr. Ernest E. Bishop, who later became superintendent of the hospital. He finished his professional career as tuberculosis coordinator for Hamilton County.

With The Branch as part of Cincinnati General Hospital, the faculty of the College of Medicine served on the medical staff of both hospitals to varying degrees. The department heads were the consulting staff at The Branch while members of the respective departments contributed their services as attending staff. This arrangement, initiated in the early days of the hospital, persisted until the hospital was closed. Over the years Dr. Dunham and his successors, Dr. Skavlem and Dr. Virgil Plessinger, attracted a steady stream of young physicians as the resident staff of the hospital. Many came for short periods of one or two years to advance their knowledge of tuberculosis before moving on to another stage in their professional careers. Others remained for years, devoting a significant part of their professional lives to the hospital and its patients. To a large extent, the history of the hospital revolves around these people.

Although staffing and treatment of the patients were excellent, the physical plant created serious problems. The main ones were chronic overcrowding and an everlasting waiting list for admission to the hospital. As a result it was difficult, if not impossible, to secure admission for the patient with minimal, but curable, disease, and facilities for the children with active disease were inadequate. A public education campaign, carried out by the Anti-Tuberculosis League and the Community Chest, publicized these facts and led to the formation of The Citizen's Committee under the auspices of the league and the Public Health Federation. The combined action of these groups led to the successful passage of another bond levy in 1926 for $250,000 to be used for the construction of the central section of the building, which many of us still remember. Two years later, in 1928, there was another bond levy for $2,000,000 for the completion of the hospital, after which there were 635 beds, with 427 located in the main building. A new preventorium, on the grounds of, but remote from the hospital, had a capacity of 100 children. Two members of the resident staff of 1926, Dr. William D. Hickerson and his wife, "Dr. Virginia," returned to the hospital 16 years later with "Dr. Bill" serving as acting superintendent and associate medical director and "Dr. Virginia" filling the positions of attending pediatrician and pediatric coordinator. Two other members of the resident staff of that year were Dr. Mary McClellan and Dr. Susan Brown. Each served for at least 10 years.

In 1927 the county leased the hospital from the city, renaming it Hamilton County Tuberculosis Sanatorium. The paid staff was transferred to the county payroll, but the medical staff and the relationship with the College of Medicine was unchanged. A year later Dr. Skavlem joined the attending staff.

The therapy of tuberculosis was still quite limited. Although a host of surgical procedures had been developed around the turn of the century, the high rates of morbidity and mortality precluded their use on a routine basis. Among such operations were the major invasive procedures of pleural decortication, thoracoplasty and the various types of plumbage, all of which had greater use starting with the development of the sulfonamides in the mid-'30s and increasing with the advent and expansion of the antibiotics starting with penicillin during World War II. These major procedures were occasionally done at the General Hospital. Therapeutic modalities performed at the sanatorium were pneumothorax for collapse of the lung, lysis of pleural adhesions, if necessary for uniform collapse, and sometimes temporary or permanent interruption of the corresponding phrenic nerve. Pneumothorax, frequently induced on inpatients, was often continued on an outpatient basis at the General Hospital Clinic after discharge from the hospital.

In the '20s and '30s the other treatment consisted of prolonged bed rest, fresh air, heliotherapy or sunshine, a graduated return to exercise and good nutrition. Credit for the dental care of the patients goes to a group of volunteer dentists and to the attending dental staff. Members of the latter group included Drs. E.W. Johnson, Vernon Chenowith and Paul Brumm. Dr. Carl Henn served the patients for over 20 years. Particular credit is due Dr. Paul Cassidy for devising and constructing a mobile dental office, complete with power drill, lights, suction and the like, to carry the dental service to the bedfast patients. Several organizations, including the Anti-Tuberculosis League, supplied funds to purchase dentures for the patients.

For many patients the treatment in those years seemed to consist of little more than enforced bed rest and fresh air. For individuals anticipating hospitalization for a year or more, the proper support for their morale was almost as important as the rest of the therapy, and more so, for some. Much thought and effort were therefore directed toward such support. Many programs were purely recreational, and included such activities as movies, card games, billiards or pool, and parties. Of greater importance for many patients were the rehabilitation programs developed in the mid-'30s under the direction of Marvin Halsey, the acting director of the Social Service Department. These programs responded to major concerns of many patients. Some facing the required prolonged period of hospitalization felt that they would lose touch with the outside world and their occupational skills would deteriorate or be lost, thus impairing their employability. Other patients knew that they would ultimately leave the hospital with physical limitations that would preclude the resumption of their previous occupation. The federal government, working through the WPA Adult Education Project, supplied and paid teachers involved in these rehabilitation programs. And at all times there was spiritual support for the patients according to the personal beliefs of each.

In addition to the hospital with its resident and attending staffs, the Anti-Tuberculosis League, the Community Chest, the Public Health Federation and the Citizens Committee, there were many other organizations that participated in the care of tuberculosis patients and their families, not only during the period of hospitalization, but also during outpatient therapy and rehabilitation following discharge from the hospital. Included in

this group were the following: Board of Health, Better Housing League, Babies Milk Fund Association, Visiting Nurse Association, city and state Employment Services, Jewish Consumptive Relief Society, Kiwanis Club of Cincinnati, Civitan Club, St. Vincent de Paul Society, Federated Garden Club, and some suburban garden clubs. Outpatient facilities for continuing follow-up and therapy were provided at the sanatorium, Cincinnati General Hospital, Shoemaker Clinic and Twelfth Street Clinic as well as outpatient clinics in various parts of the county. Particular attention is due The Good Samaritan Hospital as the only private hospital in the community that regularly maintained beds for patients with tuberculosis.

As a teaching hospital, the sanatorium had gained recognition by the American Medical Association, the American Hospital Association, the American College of Surgeons and the American Diatetic Association.

In 1929 additions to the resident staff included Dr. J.W. Leichliter as pathologist and director of the laboratories, replacing Dr. Joseph Ganim. Dr. James Christiansen and Dr. William Lippert were the other two new residents. The following year the resident staff had expanded to seven full-time physicians, one of whom was Dr. Cecil Hickam, as well as two resident pathologists. In 1934, the year in which the newly enlarged hospital was dedicated, the staff of full-time resident physicians had increased to nine with new additions consisting of Drs. Henry Felson, James Schaal and Helen Mabon. The last of this group worked almost exclusively with the pediatric patients.

Dr. A.C. Bachmeyer resigned as superintendent of The Hamilton County Tuberculosis Hospital on March 31, 1936, having served in this capacity for 22 years and two months. He was replaced by Dr. Bishop, who had been serving as assistant superintendent. Dr. Leichliter left the sanatorium to become director of laboratories at The Christ Hospital, and he was replaced for one year by Dr. James Patterson. In July Drs. Herman J. Nimitz and McKinnie Phelps joined the resident staff.

In 1937 Dr. Nimitz was appointed to the new position of tuberculosis coordinator of Hamilton County as Dr. Norton and Dr. Christiansen were promoted to associate and assistant medical directors, respectively, and Dr. David Heusinkveld joined the attending staff. New members of the resident staff included Drs. Lynne Baker and Plessinger. The latter would ultimately be the last of the medical directors of the hospital. Major surgery, which had been done at The Cincinnati General Hospital, was now being done in the new operating rooms under the supervision of the attending surgeon, Dr. B. Nolan Carter, associate professor of surgery at the College of Medicine.

New members of the resident staff starting in 1938 included Drs. Charles Castle, George Durst, Barbara Hewell and Milton Stuecheli. Dr. Robert J. Ritterhoff was the new pathologist and director of the laboratories.

Major changes took place in 1939. The name of the institution was changed to The Hamilton County Tuberculosis Hospital and it was placed under the control of a Board of Trustees consisting of Dr. Byron H. Nellons, Judge Robert N. Gorman and Dr. George Rockwell. Dr. Hewell was appointed to fill the new position of pediatric coordinator. The resident medical staff, now expanded to 10 physicians, was separated into senior and junior categories based on prior experience at the hospital. The junior residents, all new to the staff, were Drs. Charles DeWert, Harold Humphrey, Arthur Lippert, John Pryor, Bertram Snyder and Owen Yaw. Two assistant residents in pathology were Drs. Robert Garber and Dan Oscherwitz. Dr. Pryor served at the hospital for only one year and later became professor of medicine and dean of the College of Medicine at Ohio State University.

The early 1940's were characterized by a rapid series of changes in the medical staff of the hospital. The first and most significant occurred in 1940 when Dr. Dunham retired from the medical staff of the hospital, having served the hospital and its patients for more than 30 years in a voluntary capacity. Dr. Skavlem was his successor. In the early part of 1941 Dr. Nimitz was named superintendent as Dr. Bishop became tuberculosis coordinator. In June Dr. Norton retired after 24 years of service and Dr. Nimitz became the associate medical director. Later in the year several members of the medical staff, who were in the Army Reserves, were assigned to military service. Included in the group were Drs. Christiansen, Humphrey, Yaw and Martin, with Dr. Castle leaving for service with the Navy a short time later. Some of the resident staff of prior years returned on a part-time basis to help fill the gaps in the staff. This group included Drs. Susan Brown, Barbara Hewell, William Lippert and Louis B. Owens. Joining the staff as a junior resident in 1941 was Dr. Ruth Sprinkle Schwegman, the vanguard of a group of women who would make up a significant part of the resident medical staff during World War II.

Following the bombing of Pearl Harbor, when Dr. Plessinger was then stationed at Tripler Army Hospital, the medical staff of The Cincinnati General Hospital formed The 25th General Hospital for the Army. Dr. Nimitz was given military leave to serve as the commanding officer of this unit. Dr. William D. Hickerson was recalled from Mississippi, where he had been tuberculosis coordinator for that state, to serve as superintendent and associate medical director. His wife, "Dr. Virginia," became pediatric coordinator and attending pediatrician. In the summer of 1942, Dr. Virginia Congleton and Dr. Martha Hessler joined the resident staff. They, along with Dr. DeWert, who was now the assistant medical director, Dr. Schwegman and Dr. Ritterhoff formed the permanent nucleus of the resident medical staff for the duration of World War II. Although the size of the resident medical staff was reduced during the war, the number of patients also decreased as many of the less impaired patients signed out of the hospital, frequently against medical advice, and obtained gainful employment for either monetary or patriotic reasons. Following the departure of Dr. B. Nolan Carter to the Army, Dr. Edward J. McGrath became the attending surgeon at the hospital, and he personally performed the major part of the surgery done at the hospital for the duration of the war.

Following the death of Dr. Dunham on April 27, 1944, the institution was renamed Dunham Hospital of Hamilton County on February 6, 1945. At the same time the medical library of the hospital was named in honor of Dr. Vera Norton for her years of service as the associate medical director.

With the end of the war in 1945, some former staff members returned. Dr. Nimitz again became superintendent and the associate medical director as Dr. Wm. D. Hickerson became associate

medical director of The Union Central Life Insurance Co. Dr. Humphrey rejoined the resident medical staff and Dr. Plessinger returned for a year as resident pathologist under Dr. Ritterhoff.

Changes in the staff in 1946 included the return of Dr. Castle, the replacement of Dr. Plessinger as resident pathologist by Dr. Paul N. Jolly, and the appointment of Dr. Elmer Maurer to the attending surgical staff.

A major milestone in the treatment of tuberculosis was reached in 1946 with the discovery of streptomycin and the recognition by Dr. Corwin Hinshaw of the Mayo Clinic that it was effective against M. tuberculosis. Medical therapy was now available to complement the temporary collapse therapies performed by the medical staff and the permanent collapse procedures performed by Dr. McGrath with members of the resident surgical staff of The Cincinnati General Hospital, who now rotated through Dunham Hospital on a regular basis. The limited supply of streptomycin, the high cost of the drug and the undesirable side effects virtually forced the intermittent use of the drug. In an effort to determine the most efficacious, least toxic regimen for the use of streptomycin and para-amino-salacylic acid (PAS), a continuing series of large-scale studies were conducted on patients with tuberculosis in hospitals of the Veteran's Administration and the various branches of the military, along with a few private and non-federal governmental hospitals. Although Dunham Hospital was not one of the participating hospitals, Dr. Skavlem collaborated in these cooperative studies. Because of his participation, the patients at Dunham Hospital continually received the latest and best-known form of treatment.

Dr. Ritterhoff left the hospital in 1948 to become director of the laboratories at St. Elizabeth Hospital in Covington, Kentucky, and his position at Dunham Hospital was filled by Dr. Jolly. In the following year Dr. Hewell returned as pediatric coordinator, a position she filled until 1954. Dr. Robert Woliung joined the resident medical staff for one year, following which he continued on the attending staff for several years. Other additions to the resident staff included Dr. Dorothy Suyemoto and Dr. Charles Maurmeier in 1950 and Dr. Helen Ackerman in 1951. These three physicians continued with the hospital for many years, but only Dr. Ackerman remained until it closed. In 1951 Dr. Jolly joined Dr. Leichliter at The Christ Hospital and Dr. Humphrey went to Columbus, Ohio as superintendent of The Franklin County Tuberculosis Hospital. In 1952 Dr. DeWert resigned to become medical director of the Hilton Davis Chemical Co. and Dr. Congleton was appointed assistant medical director.

By 1951 the mortality rate due to tuberculosis had fallen to 29.5 per 100,000, less than 10% of what it had been four decades earlier when Dr. Dunham had first joined The Branch. Much of the decline had occurred during the five years following the advent of streptomycin. In 1952 the weekly magazine *LIFE* revealed that a previously known drug, isoniazid, was more effective against tuberculosis than streptomycin. The cover picture showed isoniazid-treated tuberculous patients dancing in the hall of their hospital. With the advent of isoniazid in 1952, a resident staff position in research was created and initially filled by Dr. Park Biehl. Under the impact of multiple drug therapy, deaths due to tuberculosis fell to 68 by 1954.

In 1953 Dr. Richard Witt joined the resident staff for a year after which he served in a part-time capacity until 1959 when he became director of research. Dr. Frank Kellog replaced Dr. Hewell as pediatric coordinator in 1954 and he retained this position until the hospital closed. In the same year Dr. Louis Buente was appointed as assistant attending surgeon to serve with Dr. Maurer. Dr. Skavlem resigned as medical director of Dunham Hospital in 1957 and Dr. Virgil Plessinger was appointed to serve as the last medical director on February 7, 1957. The staff was now relatively stable but it slowly decreased in size as the number of patients declined under the impact of more effective therapy. After the departure of Dr. Congleton in 1961, Dr. Suyemoto was appointed as assistant medical director, and she was followed in 1971 by Dr. Helen Ackerman, who held the position until the hospital was closed. Dr. Maurmeier left the hospital, prior to its closing, to become the director of the Tuberculosis Control Center for the County.

The progressive improvements in the medical therapy of tuberculosis lead to increased outpatient therapy with a corresponding decrease in the need for hospitalization. Although the capacity of Dunham Hospital was 456 patients, the number of patients had dropped to 288 by 1957. In August of 1960 Allen House, which provides temporary shelter and care for children, was moved onto the grounds of Dunham Hospital, utilizing the space that had been the preventorium. By 1967 it was obvious that the need for a hospital dedicated to the treatment of tuberculosis was rapidly coming to an end. Many proposals for the use of the hospital were given serious consideration by the Board of Trustees and by county commissioners, but none was practical. On January 28, 1971, the Board of Trustees voted to close Dunham Hospital and to turn the area over to the Cincinnati Recreation Commission. It was felt that the further care of the remaining 55 patients could be provided at Cincinnati General Hospital and at Drake Memorial Hospital, and that treatment of the ambulatory patients could be performed in clinics. During the last year of its existence, Dunham Hospital admitted only 158 patients and the total number of deaths had dropped to 25, of which about half were attributed to tuberculosis and the remainder to other causes.

Since the closing of Dunham Hospital, the treatment of most tuberculosis patients has been provided by the Tuberculosis Control Center. Most are now treated on an outpatient basis and only an occasional one requires hospitalization, usually for only a few weeks.

The need for an institution like Dunham Hospital, dedicated to the treatment of tuberculosis, no longer exists in this area. Sporadic cases of active disease still occur, and within the community there are a host of individuals who still harbor viable organisms in an inactive phase of the disease. Every one of these persons will retain a remote but lifelong potential for active, infectious disease, so the hope for eradication of tuberculosis is unrealistic. Moreover, the incidence of tuberculosis is again on the increase. At particular risk are the individuals with depressed immunity, whether viral in origin or drug-induced following organ transplantation. May we never need another Dunham Hospital!

This article was reviewed by members of **OHIO Medicine's** *editorial review board.*

Employment Opportunities

ATHENS MENTAL HEALTH CENTER, a 224-bed, JCAHO-accredited, Medicare/Medicaid certified, state-operated, inpatient psychiatric hospital has full-time and part-time positions available for BC/BE psychiatrists and psychiatric physicians. AMHC serves as a multiple discipline training base for Ohio University and the College of Osteopathic Medicine. Possible teaching and private practice opportunities available. Competitive salary and excellent benefits package. Community offers cosmopolitan atmosphere with small town convenience, cultural activities, progressive school system, favorable cost of living and an abundance of recreational opportunities. Call or send CV to Athens Mental Health Center, Athens, OH 45701, Attn: Mary Jo Ford (614) 592-3031.

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At the end of our term the MSS wants to see a larger group of students active in organized medicine in Ohio and in legislative issues. We want to solidify our new rational strength and develop leadership in our own group to ensure continuity for the Ohio-MSS. We have high hopes of becoming the most successful OSMA-MSS to date, and are continuing to work with the OSMA toward the achievement of common and challenging goals.

Cindy Smith, Wright State University, is President of the OSMA-MSS.

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Is your office staff at wits' end trying to comprehend the intricacies of Medicare billing? For ophthalmology practices, the answers to your questions may be just a call away.

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AMA Report

• **Geriatric Management . . .** The AMA is co-sponsoring with the American Geriatrics Society a conference, "Clinical Update in Geriatric Management," October 27-28 in Chicago. Speakers will provide current information on clinical assessment and management of geriatric patients. Details are available from Therese Mondeika, 312-645-5069.

• **Antitrust Advice . . .** The AMA has established the Physician Negotiation Advisory Office within the Office of the General Counsel. The purpose of the new office is to educate physicians about the antitrust laws and to improve their ability to negotiate with payors and employers. The Physician Negotiation Advisory Office has developed a booklet that explains the antitrust laws and describes the steps physicians and medical societies can take to bargain more effectively with payors.
The office staff will also refer physicians in need of representation on these issues to attorneys in their area. For further information regarding the services of this office, or to discuss a particular issue, call Michael L. Ile or Laura A. Kroll at 312-645-6546.

• **Medical Necessity Requirements Explained . . .** In order to give physicians and their staffs a thorough understanding of Medicare's "medical necessity" requirements, the AMA has just released a new publication, "Medicare Carrier Review: What Every Physician Should Know About 'Medically Unnecessary' Denials." The informative, 60-page booklet was prepared by the AMA with technical assistance from the federal Health Care Financing Administration. Copies of the booklet are available for AMA members at $10 each, $12.50 for non-members. Prepaid orders should be sent to: AMA, P.O. Box 10946, Chicago, IL 60610-0946.

• **A Few Good Physicians Needed . . .** Project USA, the AMA's program that recruits physicians for short-term service in rural areas, is seeking physicians to practice family medicine at National Health Service Corps and Indian Health Service locations. All Project USA physicians receive a weekly stipend, round-trip coach airfare and living accommodations. For information on dates and locations, contact John Naughton, c/o The American Medical Administration, 535 N. Dearborn, Chicago, IL 60610 (312) 645-4702.

• **Preventing Violence . . .** The AMA Conference on the Prevention of Family Violence and Victimization will be held October 5-7 at the Chicago Hilton and Towers Hotel. Designed for physicians, mental health professionals or administrators, the multidisciplinary conference will emphasize current research and policies and practices involved in diagnosing and treating family violence. Workshop topics include the cycle of abuse; spouse, elder and child abuse; the relationship of drugs and alcohol to family violence; and legal and policy issues. Outgoing Surgeon General C. Everett Koop, MD, will open the conference. The AMA designates this continuing medical education activity for up to 15 credit hours in Category I of the Physician's Recognition Award of the AMA. The conference fee is $225. For more information, call 800-621-8335.

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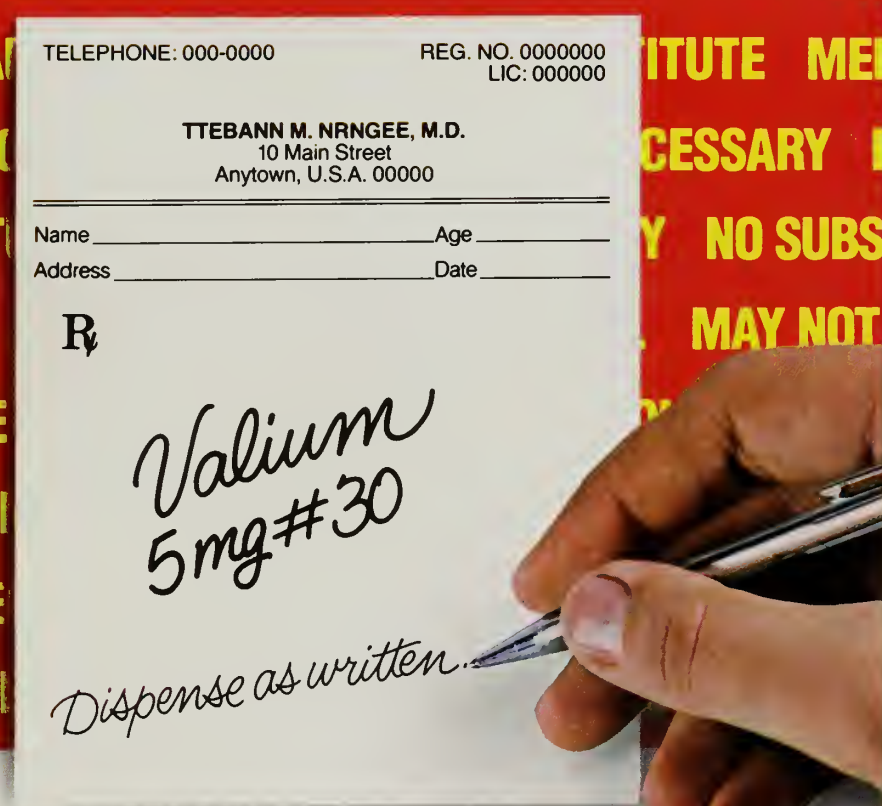

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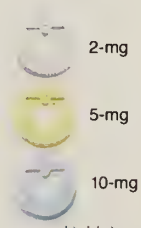

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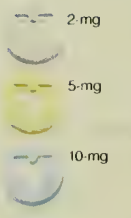

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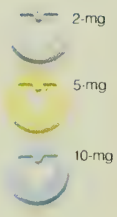

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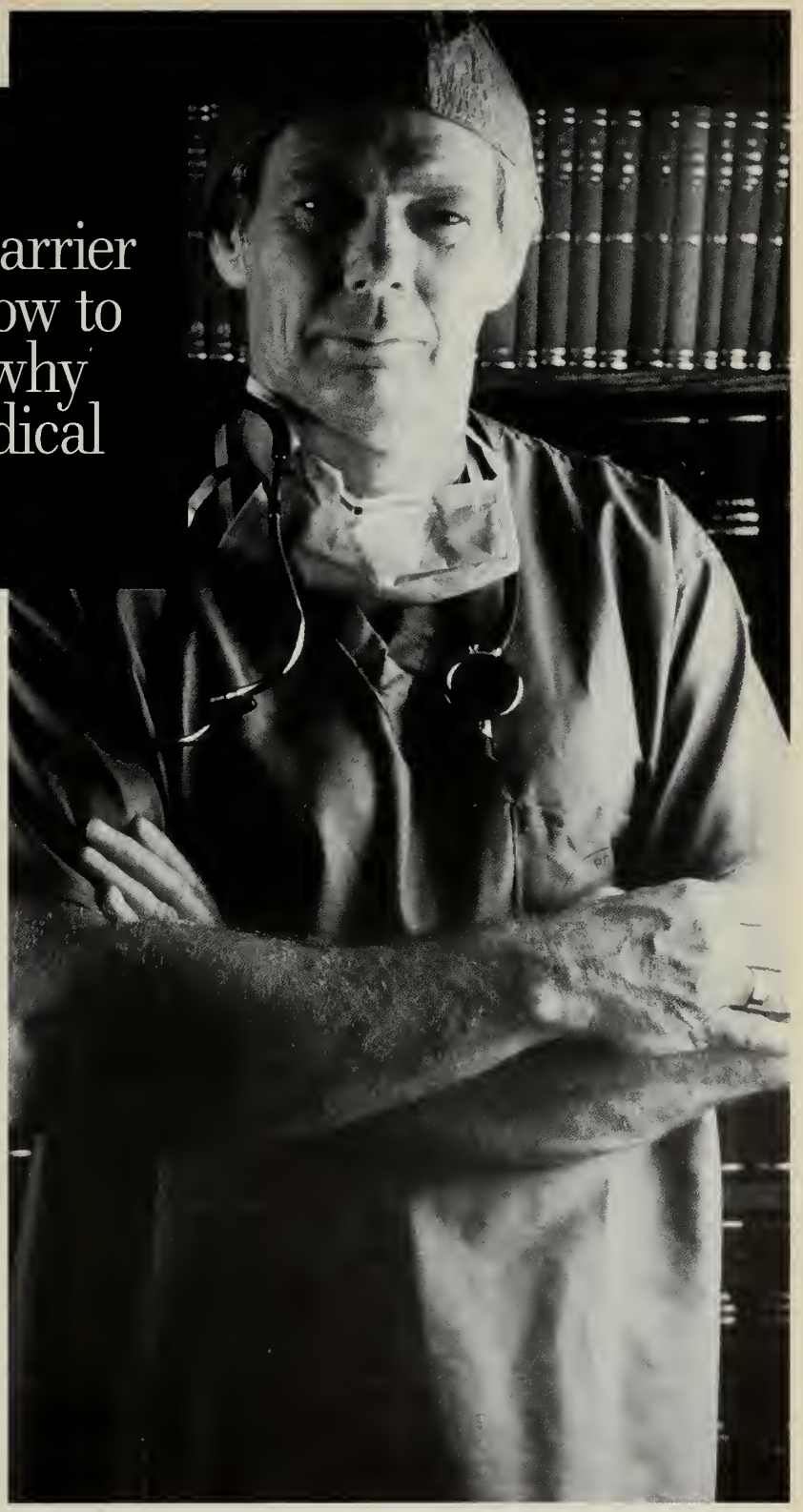

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Published monthly under the direction of The Council for and by members of OHIO Medicine, 1500 Lake Shore Drive, Columbus, Ohio 43204-3824, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1989 Subscription: $25 per year.

Send address changes to: OHIO Medicine, 1500 Lake Shore Drive, Columbus, Ohio 43204-3824.

Second Class Postage paid at Columbus, Ohio and at additional mailing offices.

OHIO Medicine does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

FROM THE EDITOR

Private Judging . . . Has Its Time Come?

One of the problems with being sued for malpractice (and we don't mean to trivialize — we know there are many) is the length of time it takes for the case to come to trial. Granted, some of that time is needed for preparation, but to prolong the unpleasantness makes the experience even more annoying and nerve-wracking than it already is. Yet help may soon be on the way.

Lawrence Grey, JD, judge of the Fourth Appellate District and a frequent contributor to *OHIO Medicine,* was recently appointed to a committee that is drafting rules for private judging. In this issue, he takes a look at the private judging system, explaining what it is and how it might help to expedite those lingering malpractice cases that are flooding our present court system. Whether or not it will be the shot in the arm this state's malpractice-weary physicians need is unclear at this point, but it may provide advantages beyond the speedy trials. For example, under the private judging system, physicians may enjoy increased privacy and perhaps the court's increased understanding of complex medical cases, since it's entirely possible some judges will specialize — like physicians — in certain areas, i.e. hearing medical cases. According to Judge Grey, private judging is about five years away here in Ohio (California already has a private judging system). Still . . . it may be worth the wait.

Another matter we look into this month is the controversial area of steroids. With the amount of illegal activity focused around this growth-enhancer, it's important for you to know how this common treatment of choice is being abused by big-time and even small-time athletes. Assistant Editor Michelle Carlson may shed some light on this perplexing problem for you as she pursues the controversy.

The report from the latest AMA meeting is also included in this issue. If you want a good idea of the types of issues organized medicine is addressing today . . . and now it's choosing to address them . . . make a point of reading the article. Then, go one step further. Get yourself involved in those issues . . . whether it's at the local, state or national levels. Organized medicine is only as strong as its members. Get involved and strengthen medicine's stand.

"Ohio Medi-scene" this month is a must for the sports enthusiast. Within its pages you'll find a report of the high school football team physicians who were recently recognized by the OSMA Joint Advisory Committee on Sports Medicine.

Next month, of course, the OSMA will sponsor its Annual Scientific Session — this year in Dayton. Details of the programs to be presented by various specialty groups are included in this issue, along with all the information on how, when, where to register. Make plans now to attend. See you there!

Karen S. Edwards

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OCT 11 1989

ISSN 0892-2454
USPS 405-200

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OUR COVER:

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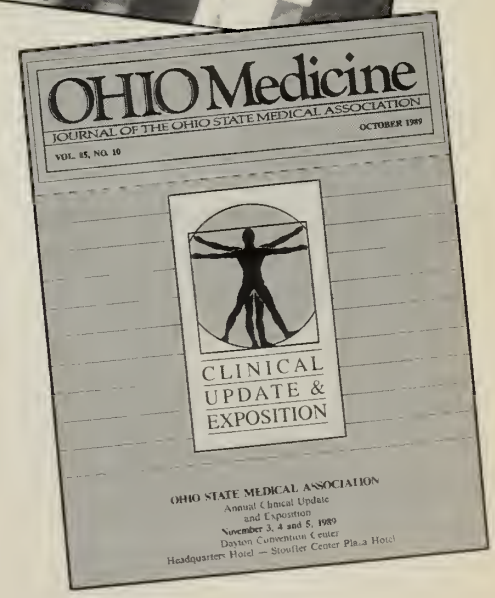

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By William J. Marshall, MD
President of the OSMA

The title was meant to catch your eye. Every physician has a strong sense and commitment to caring and curing. James E. Davis, MD, then president of the AMA, in his June 1988 inaugural address discussed the profession's sense of service. He noted evidence that doctors are donating increasing amounts of care. A recent survey of primary care physicians revealed 68% had volunteered their time at a free clinic, nursing home or other social service health agency. Another recent study revealed that one-third of all care rendered by emergency physicians is donated. So now you know the first part — I'm looking for volunteers for "The Caring Program for Children."

What about the second part — "two to 18"? These numbers encompass the age groups this new volunteer program will serve. George F. Will in *Newsweek,* December 1978, said, "Childhood is frequently a solemn business for those inside it." In a further attempt to define a classification of patients in this age span, let me quote Ellen Karsh, *New York Times,* January 3, 1987. "He is a teen-ager, after all — a strange agent with holes in his jeans, studs in his ears, a tail down his neck, a cap on his head (backwards)."

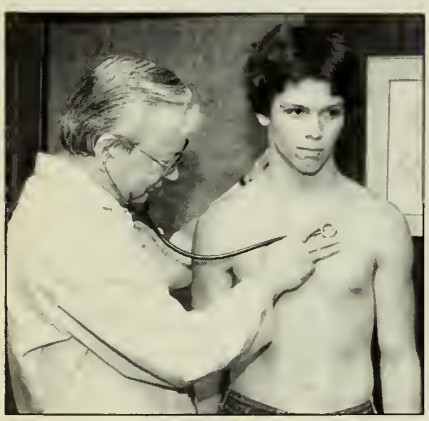
A third factor is poverty. This program is limited to families with the lowest income, those whose family incomes are less than 100% of the federal poverty level. The program is about prevention in this subset of patients, estimated to be 160,000 children of the "working poor" without health insurance, living in Ohio.

"The Caring Program for Children" is being sponsored by Community Mutual Blue Cross and Blue Shield (CMIC). This company, in its 50th anniversary year, wished to return something tangible to the people of Ohio as a part of its celebration. Several months ago, Dwane R. Houser, Chairman of the Board and Chief Executive Officer, approached Herb Gillen, OSMA Executive Director, about the possibility of a cooperative effort to enhance the success of such a program. The project was presented to your Council and officers, and after careful study and consultation, the Council on July 15, 1989 voted to join CMIC in this effort to help a segment of the uninsured in Ohio.

This program is charitable and will be limited primarily to outpatient preventive health care. It will be funded by donations from businesses, charitable foundations, organized labor, religious and civic groups, and individuals. CMIC has pledged to match private contributions up to $1 million a year and to absorb all administrative costs of the program.

What is medicine's contribution to this program? I am asking physician members of all disciplines within the OSMA to volunteer to participate in this program. We must do the caring and curing. From the definition of patient population to be served, it would seem the majority of care

will be rendered by pediatricians and other primary care physicians. The scope of the coverage envelops unlimited office visits, inoculations and immunizations, outpatient surgery, outpatient diagnostic tests and prescription drugs commonly prescribed for children. Volunteer physicians will be reimbursed for their usual fee, their actual charge or 65% of the customary maximum payment CMIC allows for its traditional business — whichever is lowest of the the three. Any remainder will represent a tithe of their time and service. Physicians will have the right to limit the number of Caring Program patients they accept and can drop out of the program at any time with 30 days' notice.



The gathering of a volunteer group such as this requires a grass-roots effort. I have asked each of the 12 councilors to discuss with medical society officers within their districts the organizational aspects necessary to get this program under way. Contracts will be mailed to physicians so that they may volunteer. An anticipated start-up date for enrollment and coverage is Nov. 15, 1989, pending receipt of initial contributions.

I am confident that there are many OSMA members who will accept this challenge. Your councilors and officers of the OSMA thank you for your commitment and service in this voluntary effort. **OSMA**

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Head Injury Recovery Center at Clifton
625 Probasco, Cincinnati, Ohio 45220

A Combined Effort for Adolescents

By Barbara Marshall
President of the OSMA-A

The AMA's "White Paper on Adolescent Health," published in December 1986, revealed some startling findings regarding the problems facing today's teen-agers. Out of this study grew the AMA Adolescent Health Initiative, a broad program to improve the health of the nation's youth. Focus has been in five areas responsible for an increase of 11% in morbidity and mortality rates of this group from 20 years ago: substance abuse, sexuality and pregnancy, victimization, psychological disorders and suicide, and violence and trauma.

The AMA Auxiliary and its component auxiliaries have been committed to the Adolescent Health Initiative since its beginning and have undertaken thousands of community projects on teen health. Emphasis has also been placed on programs that promote a healthy transition into adolescence.

Improving the health of adolescents can be done most effectively when the process includes schools, physicians, parents, community and youth. This year the OSMA Auxiliary has several opportunities to work in coalition with others in this area. On September 18-19, the OSMA and OSMA Auxiliary will join with other volunteer organizations and state agencies to sponsor "Age of Choice: Rescuing the Future," an adolescent conference that will deal with issues and challenges, strategies, programs and responses, and empowerment. It is designed to bring together service providers, concerned citizens and youth. A workshop on the issue of teen pregnancy will be under the joint sponsorship of the OSMA and OSMA Auxiliary. The auxiliary will pay the registration fee for 20 county health projects chairmen.

Three of our counties, Seneca, Trumbull and Scioto, will participate in a program begun by the National Collaboration for Youth. Following an hour-long ABC-TV program on September 14, they will convene local town summit meetings where the subject will be "Making the Grade — A Report Card on Local Youth." Working in coalition with community youth agencies, these meetings will bring together participants from every level of the community who share an interest in the well-being of local teens, to determine what the community offers its teens and to arrive at a plan of action that can be implemented by a collaboration of concerned citizens from all sectors.

Auxiliaries have been asked to work with the American Academy of Family Physicians and the American College of Obstetricians and Gynecologists on their public education campaign regarding teen pregnancy prevention. The campaign this year will focus on the male's responsibility. We will contact local radio and television stations to ask them to air public service announcements and will distribute posters and brochures entitled "Straight Facts for Men About Sex."

Representatives of the OSMA, OSMA Auxiliary, AMA, Ohio Department of Health, Ohio Department of Education, Physicians Health Plan, Cleveland Academy of Medicine, key physicians and others have participated in a planning session to discuss the possibilities of a long-range HIV education project for Ohio youth.

Working together is an important first step in addressing the important issue of adolescent health.

Physicians + Auxilians = Equation for Change! OSMA

OSMA Auxiliary Fall Confluence

Friday, October 13, 1989

Join auxilians from across the State of Ohio to participate in an exciting conference co-sponsored by the WRIGHT STATE UNIVERSITY SCHOOL OF MEDICINE.

Begin with a WINE AND CHEESE reception Thursday evening, October 12, 1989, 6:30 - 9:00 p.m. in the **WSU CONTEMPORARY ART GALLERY.** The **OHIO WINE GROWERS** will provide the program.

FRIDAY, OCTOBER 13, 1989

PROGRAM

"THE MIDDLE YEARS: THE SANDWICH GENERATION"

8:00 a.m.

Continental Breakfast,
WSU School of Medicine Lecture Hall

8:30 a.m.

Plenary Session
Demographics of the Middle Years Generation
(Who we are, where we live, how is our health)
Sherry Stanley, MD

9:30 a.m.

Break and move into workshops

10:00 a.m.

Concurrent Workshops: (select A or B)
(A) Morality and the Law: What is the Law's Claim on Me?
Robert D. Reece, PhD
The social problems of the middle years - does the law solve them or does it create them?
(B) The Middle Years Generation: A Powerful Political Force.
James Jacob, PhD
The middle years generation is the prime of life — economically, socially and politically.

11:15 a.m.

Move into Luncheon Area

11:30 a.m.

LUNCHEON IS SERVED

12:30 p.m.

KEYNOTE SPEAKER
DONNA T. PEPE
Executive Director, Public Relations, Ortho Pharmaceutical Corporation
Topic
"MARKETING PRESCRIPTION DRUGS TO WOMEN IN THE MIDDLE YEARS THROUGH THE USE OF THE MEDIA"

1:30 p.m.

Concurrent Workshops: (Select C or D)
(C) Body and Soul: How to create a realistic balance between my positive thinking and my physical capabilities.
Judith Tangeman, MD

1:30 p.m.

(D) Self Affirmation:
Flaunting Our New Sense of Self.
(speaker to be announced)
Wonderful things happen when we affirm ourselves.

2:30 p.m.

Return to WSU Medical School Lecture Hall

PLENARY SESSION
"DISPELLING THE MYTH OF DECLINING SEXUALITY IN THE MIDDLE YEARS"
Elaine Koenigsberg, MSW
We will explore and discuss the choices and opportunities which present themselves to us in this very personal part of our lives.

3:30 p.m.

EVALUATIONS

Donna T. Pepe, Executive Director, Public Relations, Ortho Pharmaceutical Corporation, is responsible for the Public Relations Department including Public Affairs, Internal P.R. Communications, and P.R. programs for new and existing products. Donna joined Ortho in October 1983 after considerable experience in pharmaceutical public relations. She had worked as Account Supervisor with the Burson-Marsteller agency and as a free-lance public relations consultant. In addition, Donna had experience in public affairs at the Methodist and LaGuardia Hospitals in New York. Since joining Ortho, Donna has established a very active Public Relations Department servicing all divisions. As Executive Director, Donna will continue to expand the role of public relations in the company.

Registration Form

Name: _____ Phone Number: (____) _____

Address: _____ Zip: _____

Please mark attendance at following events:
_____ Thursday evening reception: WSU Contemporary Art Gallery Wine and Cheese reception
Friday Confluence
The Middle Years: The Sandwich Generation
Concurrent Workshops in morning session--select one
_____ (A) Morality and the Law
_____ (B) Political Power in the Middle Years
Concurrent Workshops in afternoon session-- select one
_____ (C) Body and Soul
_____ (D) Self Affirmation

REGISTRATION FEE is $50. Guests are welcome.
Checks payable to OSMA-A.
Mail to: Mrs. John Rich, 4655 Glenheath Drive, Dayton, OH 45440.
Information: Sara 1-513-434-6669 or Sally 1-513-433-1911.
Reservations accepted until Monday, October 9, 1989.

Hotel reservations must be sent directly to Holiday Inn Conference Center/I-675 or call 1-513-426-7800.

The Ninth Annual Richard L. Fulton, M.D. Memorial Seminar

Tuesday, October 10, 1989
7:30-9:30 A.M.
Susan H. Edwards Auditorium
Riverside Methodist Hospital
Columbus, Ohio

GUEST LECTURER:
Roger D. Blackwell, Ph.D
Professor of Marketing
The Ohio State University

TOPICS:

7:30 A.M. "The Economics and Ethics of Macromarketing of Health Care"

8:30 A.M. "The Economics and Ethics of Micromarketing of Health Care"

Riverside Methodist Hospitals designates this activity as meeting the criteria for two Category I CME credit hours.

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Spectrum Emergency Care, Inc.
P.O. Box 27352
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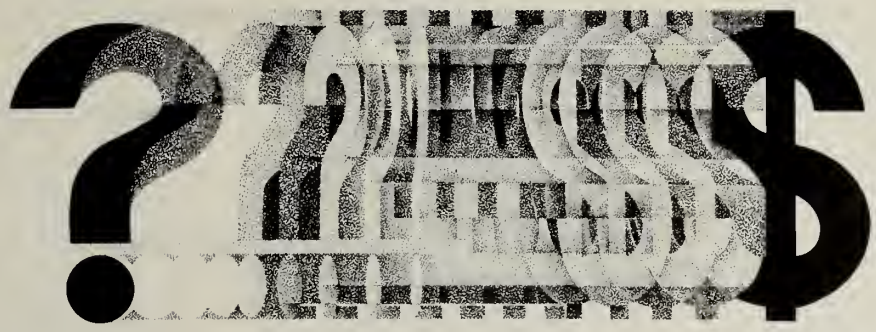


An Essay on Choices . . .

By Joseph C. Noreika, MD, MBA

I told Mrs. Belmont's daughter that I would not perform surgery on her mother's eyes. In truth, her mother did have significant cataracts in both eyes. Her family doctor had told her that. The cataracts were severe enough to interfere with reading, doing needlework and driving a car. I have removed cataracts from other patients less disabled than her. But I counseled her daughter that cataract surgery was not indicated.

Mrs. Belmont is 91 years old. She has been in a nursing home for three years and is one of three million patients with Alzheimer's disease. Her brain no longer works. As the disease progressed, thinking and understanding became as remote to Mrs. Belmont as Michael Jordan's slam dunk is to me. Mrs. Belmont has a heart pacemaker, an artificial hip, little bladder control, is deaf, requires an oxygen tank to breathe and must take a myriad of colorful pills every day to help regulate these bodily functions.

If I was to do cataract surgery on Mrs. Belmont, she might see better. Unfortunately, she would still not comprehend what she saw. Throw in the hospital and operating room charges and it could be done for about $3,500 dollars, about the cost of a new Yugo. The federal government would have paid for most of it. Being a participating physician in the Medicare program, the surgery would have been "free." Of course, I'm not allowed to say that but it is understood. Why, then, would I not provide the surgery?

It is estimated that Medicare will operate at a $27.3 billion dollar deficit by the year 2000. Pessimists say that it might be closer to $62.5 billion dollars. These figures are based on current programs and can increase dramatically if pending legislation is enacted to include long-term and home care proposals. This will occur despite the many efforts directed at health-care cost-containment over the last 18 years. The elderly have watched their Medicare premiums and deductibles increase while services have diminished. This is designed to decrease the volume of health-care provision. Competition among health-care providers was supposed to lower prices. It stimulated demand by increasing public awareness of health issues and raised costs by providing more services. Those Wall Street wunderkinds of competitive health care, the HMOs, are currently having a tough time of it. Hospitals, doctors and other health-care suppliers have been targeted for cost cuts to squeeze the excess out of the system. These attempts have failed because whenever the balloon is pinched, another bubble appears elsewhere. For example, cost reductions caused by decreased utilization of in-patient services led to a mushrooming of costs in the outpatient sector. The ripple effect of decreased reimbursement to hospitals and doctors will continue to be felt by the public and private sector but Medicare costs continue to rise. Why?

First, let me say that complexity does not begin to describe the problem. Simplistic answers have led to short-term solutions destined for failure. However, some facts are known. This country is getting older. The fastest growing age cohort includes those people

85 and older. Not coincidentally, their health-care costs are double even those seniors who are 65 years old. Medicine has done wonders by applying technology to conquer infectious disease, diminish the occurrence of heart disorders and stroke, and control cancer. But medical research has not fared as well against the chronic, long-term, terribly debilitating illnesses that occur to the oldest of the old — Alzheimer's, Parkinsonism, osteoporosis and the rest. The cost of these disorders to society is astronomical and growing.

There are movements afoot to address the Medicare morass. As seen by the most recent budget proposal, cost-cutting is still very much in vogue. President Bush has earmarked another $5 billion dollars in cuts. This is merely cosmetic. Some have advocated more dollars spent on research to defeat the ravages of old age. More to the point, others have suggested that care be rationed and that the rationing criteria be based on age. Precedent is set. The National Health Service in Britain will not pay for coronary bypass operations for patients over 55. Economically, it is well recognized that rationing hurts the have-nots more that the haves. State-run health-care plans have fostered impressive two-tierd sytems whereby private medicine will furnish excellent, timely care if you can afford it. Those who cannot must wait, if it is available at all. It is conceivable that the decision to remove a cataract or begin kidney dialysis or undergo open-heart surgery will be mandated, not by the recommendations of a physician in concert with the needs and desire of a patient and her family, but by universal guidelines based on reams of statistical analysis that delineate the age at which a certain treatment ceases to be cost-effective.

It is a tough problem. Health care has an insatiable appetite for dollars. When your body has somehow gone bad, there can never be too much health care. In striving to provide longer life, high-technology expenditures can continue to escalate without an endpoint. Someone will need to decide where the limit lies. Otherwise, equally important areas such as education, housing and defense must necessarily suffer. Public opinion is very clear on this. We want more and better medical care but are unwilling to pay higher taxes for it.

Before we lose control of the decision-making process, it may be time to exercise personal constraint. I firmly believe that many elderly do not wish to prolong life at all costs. I believe that quality of life should be the overriding determinant when deciding to extend the length of one's life. Quality is subjective but it implies dignity, respect, sense of worth and independence. Absent these, a longer life is not worth living.

When dealing with an aged loved one, a family should decide to provide comfort, love and safe-keeping. A physician must be very clear as to the reasonable medical options and proffer the best estimate of their impact on quantity *and* quality of life. Above all, the patient's wishes must be honored and they do have a right to die with dignity. Certainly, this consideration alone cannot solve the Medicare dilemma. But it is proactive and the decision-making process remains at the level of the individual.

Mrs. Belmont's daughter chose to accept my advice. A short time later, she called to thank me again after her mother had peacefully died in her sleep. **OSMA**

Joseph C. Noreika, MD, is a Medina ophthalmologist.

OSMA Councilors

Listed below are the OSMA Councilors and the districts they represent. If you have any questions or concerns regarding OSMA, please address them to your Councilor.

First District
Stanley J. Lucas, MD
2905 Burnet Avenue
Cincinnati, Ohio 45219
Adams, Brown, Butler, Clermont, Clinton, Hamilton, Highland, and Warren

Second District
Walter A. Reiling, Jr., MD
2200 Philadelphia Drive, Suite 548
Dayton, Ohio 45406
Champaign, Clark, Darke, Greene, Miami, Montgomery, Preble, and Shelby

Third District
William H. Kose, MD
200 W. Pearl Street
Findlay, Ohio 45840-1394
Allen, Auglaize, Crawford, Hancock, Hardin, Logan, Marion, Mercer, Seneca, Van Wert, and Wyandot

Fourth District
Su-Pa Kang, MD
3900 Sunforest Court, Suite 104
Toledo, Ohio 43623-4498
Defiance, Fulton, Henry, Lucas, Ottawa, Paulding, Putnam, Sandusky, Williams, and Wood

Fifth District
Henry G. Krueger, MD
24700 Lorain Road
North Olmsted, Ohio 44070
Ashtabula, Cuyahoga, Geauga, and Lake

Sixth District
Robert C. Reed, MD
985 Sawberg Avenue, NE
Alliance, Ohio 44601-3590
Columbiana, Mahoning, Stark, and Trumbull

Seventh District
Nermin D. Lavapies, MD
Martins Ferry Hospital
92 North 4th Street
Martins Ferry, Ohio 43935
Belmont, Carroll, Coshocton, Harrison, Jefferson, Monroe and Tuscarawas

Eighth District
John F. Kroner, Jr., MD
Box 708
Athens, Ohio 45701
Athens, Fairfield, Guernsey, Licking, Morgan, Muskingum, Noble, Perry, and Washington

Ninth District
Richard Villarreal, MD
613 Center Street
Wheelersburg, Ohio 45694-1795
Gallia, Hocking, Jackson, Lawrence, Meigs, Pike, Scioto, and Vinton

Tenth District
Claire V. Wolfe, MD
793 West State Street
Columbus, Ohio 43222
Delaware, Fayette, Franklin, Knox, Madison, Morrow, Pickaway, Ross, and Union

Eleventh District
Charles G. Adams, MD
13906 W. Lake Road
Vermilion, Ohio 44089
Ashland, Erie, Holmes, Huron, Lorain, Medina, Richland, and Wayne

Twelfth District
Jack L. Summers, MD
75 Arch Street
Suite B2
Akron, Ohio 44304
Portage and Summit

CONTINUING MEDICAL EDUCATION

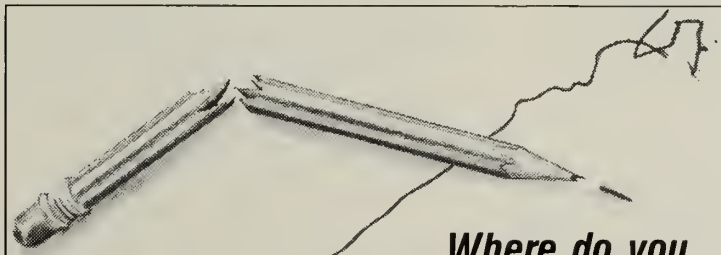
New Developments in the Multidisciplinary Treatment of Sarcomas
When: October 25, 1989
Where: Beachwood Marriott
3663 Park East
Beachwood, Ohio
Credit: 7 hours in Category I
Fee: $65, physicians
$15, residents, students, nurses
Sponsor: Northeast Ohio Society of Clinical Oncology, American Cancer Society, Cuyahoga County Unit, Cleveland Clinic Educational Foundation
Contact: Billie J. Moore or Liz D. Norton, Northeast Ohio Society of Clinical Oncology, 11001 Cedar Ave., Suite 600, Cleveland, OH 44106-3087, (216) 229-2200.

Multiple Sclerosis — 1989
When: October 20, 1989
Where: Embassy Suites Hotel
2700 Corporate Exchange Drive
Columbus, Ohio
Credit: 6.5 hours of Category I
Fee: $90, physicians. Residents, interns, fellows, nurses will receive a 50% discount with a letter from their program director.
Sponsor: The Ohio State University Center for CME
Contact: The Ohio State University Center for CME 800-492-4445 or 614-292-4985

Magnetic Resonance Intense Weekend — Ortho Review
When: November 3-5, 1989
Where: Westin Hotel
Cincinnati, Ohio
Credit: 18 hours, Category I
Fee: $575, physicians; $425 for residents and technologists; $625 for on-site registration
Sponsor: MR Education Foundation, Inc.
Contact: MR Education Foundation, Inc.
P.O. Box 813
Cincinnati, Ohio 45201-0813
606-341-8154

Pediatric Neurology Update
When: November 1, 1989
Where: Bunts Auditorium
Cleveland Clinic
9500 Euclid Avenue
Cleveland, Ohio
Credit: 6 hours, Category I
Fee: not specified
Sponsor: The Cleveland Clinic Educational Foundation
Contact: The Cleveland Clinic Educational Foundation
9500 Euclid Avenue
Cleveland, Ohio 44106
800-762-3172

Occupational Medicine Update
When: November 3-4, 1989
Where: Bunts Auditorium
Cleveland Clinic
9500 Euclid Avenue
Cleveland, Ohio
Credit: 9 hours, Category I (approximately)
Fee: not specified
Sponsor: The Cleveland Clinic Educational Foundation
Contact: The Cleveland Clinic Educational Foundation
9500 Euclid Avenue
Cleveland, Ohio 44106
800-762-3172



Where do you draw the line?

As a mental health professional, you are usually able to meet each patient's individual needs with effective treatment and positive results.

But there are some individuals whose problems seem resistant to every avenue of outpatient treatment. As a concerned professional, where do you draw the line between giving patients your best and drawing on the inpatient resources of others?

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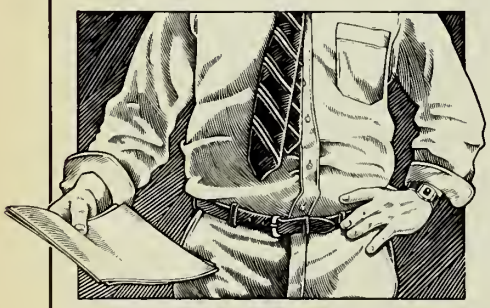
OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians

Ohioans live in "the fat belt"

According to a 1987 survey by the Centers for Disease Control (CDC), four Midwestern states plus North Dakota form what is being referred to as "the fat belt" in the U.S.

The survey found that, on the average, Midwesterners weigh more than individuals in the Northeast or in the West. Ohio was ranked the fourth most corpulent state in the country with 25% of its adult population considered to be overweight.



The CDC surveyed over 45,000 adults in 32 states to assess their body mass index scale (weight in kilograms divided by height in meters squared). According to the survey's criteria, a rating of 27.8 and higher for men and 27.3 and higher for women indicated a weight problem. American adults with a body mass index in the top 15% were considered overweight.

Heavyweight states in the survey included Indiana (the top heavyweight), Wisconsin, West Virginia, Ohio and North Dakota. States in the featherweight category included New Mexico (the slimmest of the bunch), Hawaii, Utah, Montana and Arizona.

"State and regional variations . . . may result from differences in eating habits and exercise practices," the agency suggested. CDC also pointed out that the fat belt might be even wider than the survey suggests because people don't always tell the whole truth about their weight.

While the survey suggests that many adults should be tightening their belts, a study by the Calorie Control Council reports that the number of dieting Americans has actually been decreasing in the past several years. One in four adults — approximately 48 million individuals — say they are currently dieting, which is a 26% drop from a 1986 survey.

This non-dieting trend doesn't necessarily call for a few extra notches on the belt. Even though dieting may not be as popular as it once was, people tend to be eating better and exercising more, the study says.

The Calorie Control Council, a manufacturer of low-calorie products that tracks U.S. diet trends, says the majority of adults — 93 million — consume low-calorie goods and exercise two to three times a week. Yet 59% of these consumers say they are not dieting; they are eating lighter and exercising to maintain good health.

Arthritis treatment expanded

Many patients with severe rheumatoid arthritis aren't aware of the full scope of available treatments, says Boston researcher Michael Weinblatt. And it's not patients who are left in the dark; in some cases, he says, even some doctors are unaware of new medications that are available.

Dr. Weinblatt made his remarks in Cincinnati in June at the Annual Meeting of the American College of Rheumatology. According to one report, rheumatic diseases affect more than 37 million people nationwide and 200,000 people in the Cincinnati area.

"There's a perception that it's (rheumatoid arthritis) not a serious disease . . . (that it's) without a serious treatment and that's wrong," Dr. Weinblatt says.

New arthritis medications are now available that can help patients who have shown little improvement with more traditional lines of treatment, such as non-steroidal anti-inflammatory drugs (NSAID) or even gold injections and anti-malarial compounds.

A study in Houston found that 73% of children with juvenile rheumatoid arthritis who failed to respond to other drugs showed marked improvement with methotrexate, an anti-cancer drug. Researchers there reported that the anti-cancer drug produced few side effects.

Placing difficult-to-treat patients

Let your fingers do the walking . . . One call to the Brown Schools National Information and Referral Service may be all mental health professionals need to find the appropriate treatment facilities for difficult-to-treat patients.

Best of all, the service is free.

The referral service, based in Austin, Texas, offers access to over 2,000 psychiatric and rehabilitation facilities from coast to coast. Referral specialists provide information such as hospital location and size, variety of programs and available funding. Facilities must meet selection criteria to be included in the service.

According to a recent press release, the Brown Schools hospitals have long been used as an informal referral source for patient placement. The new service combines that experience with computer technology to get the job done.

The toll-free number for the service is 1-800-531-5305. Hours are 8:00 a.m. to 5:30 p.m. (CST), Monday through Friday. After-hour calls will be handled by staff on call through an answering service.

Patient examination gloves held to new standards

Since 1985 there's been a 200% increase in the demand for non-sterile latex patient examination gloves. Before the AIDS epidemic, examination gloves were used primarily as a standard in cleanliness. Now the gloves are used as a barrier against infectious diseases such as AIDS and hepatitis. The overwhelming surge in the demand for these gloves has led to some inconsistencies in their manufacturing and quality.

To ensure that patient exam gloves continue to meet proper standards, the Food and Drug Administration (FDA) established more stringent regulations on their manufacturing. The new regulations went into effect April 13, 1989.

Manufacturers must now comply with pre-market notification procedures that require written documentation — called a 510(k) — to ensure that only safe and effective products be introduced into interstate commerce. Manufactures must also comply with Good Manufacturing Practices, which provides the FDA with a written record ensuring that the product is safe and effective.

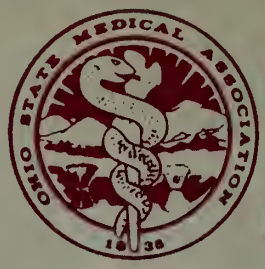
Exam gloves purchased before April 13, 1989 are not covered by the new regulations. Some sources recommend doing a quick spot check before using these gloves, looking for discoloration or thin spots around the cuff and fingers. For future orders, it's probably a good idea to stick to glove suppliers who meet the new FDA standards.

ACS releases factbook for surgery

The American College of Surgeons (ACS) has released the 1989 edition of its *Socio-Economic Factbook for Surgery*, which addresses changes in the financing, organization and delivery of today's medical services. The ACS obtained its data from sources such as the American Medical Association, the American Hospital Association and the U.S. Department of Health and Human Services.

Topics in the factbook include medical education, surgical manpower, hospital services, group practices, medical economics, health insurance and the federal government.

To receive a copy of the factbook, contact Dawn Del Rio, Office of Public Informatin, American College of Surgeons, 55 East Erie Street, Chicago, IL 60611, phone: (312) 664-4050, ext. 323.



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OHIO MEDI-SCENE

The children nobody wants . . . clinic to study pediatric AIDS . . . Ohio milestones . . . Ohio team physicians . . . hospital vogue . . .

Photo by Craig Orosz, The Journal, *Lorain, Ohio.*

The children nobody wants

Dorothy Gauchat is a reserved, soft-spoken woman, but ask her to describe the two toddlers who live with her, and she literally beams. Her face becomes animated, her voice strong. "Both of them are extremely intelligent kids," she says, smiling.

She goes on to tell you how much Prince and Jeremy have learned since arriving at her home. "That Prince knows all his colors, his ABCs . . .," that the two "scamper all over" and play together constantly.

The pair sound like any other two-year-old boys, but they're not. Prince and Jeremy are infected with AIDS.

"There are few who are advocates for the child," Gauchat says, explaining why she cares for children with AIDS.

At 68, Gauchat is no stranger to children. Forty years ago, she and her husband Bill (now deceased) began caring for children in their home, and 18 years ago founded the Our Lady of the Wayside Home, Inc., in Avon, a small town west of Cleveland, for retarded and handicapped children. She served as administrator of Our Lady up until her retirement last year. As Gauchat, puts it, "I wasn't ready to retire . . . My mission in life is, and has always been, to take care of children who have no families or families unable to care for them."

OHIO MEDI-SCENE

The children nobody wants . . . *continued*

She soon focused her attention on the rising number of pediatric AIDS cases and began researching whether there was a need for homes that would care for such children.

To learn more, Gauchat contacted Melvin Berger, MD, Chief of Pediatric Immunology and Infectious Diseases at Rainbow Babies and Children's Hospital in Cleveland (who eventually instructed Gauchat and her staff in the proper care of HIV-infected children). She also traveled to New York where she met with social workers from the Department of Human Services and to Massachusetts where she saw first-hand a home where children with AIDS are cared for.

"We did a terrific amount of research" before establishing the home, Gauchat says. "I wanted to know if there was a legitimate need. The need was there, no question about it.

"I don't think anyone knows the extent of this need," she continues.

"My mission in life is . . . to take care of children that no one else will."

"Mothers don't want to have (their children) tested because if they're positive, that means the mother is positive." Many mothers of such infants, says Gauchat, are drug users or prostitutes and are unable to care for their children because of their drug dependency or because they are too sick with the disease themselves.

"Some of the parents just abandon (their children), but other mothers are too ill to care for them," she says.

Convinced there was a need for a place where AIDS patients and other terminally ill children could be cared for, Gauchat applied for, and received, a foster care license from Children's Services of Cuyahoga County. The Colette Marie Infant Home, named after her late daughter, was finally established.

The first infant to arrive at Gauchat's home was Prince. He had spent most of his young life in a New York hospital, but Gauchat managed to cut through the red tape that held him there, and in November 1988 returned with him to Avon. Jeremy arrived at the home in June.

While Gauchat is licensed to care for five children (she has a staff of two nurses and three direct care workers), she is in the process of negotiating to have another house moved onto her property so that she will be able to accommodate an additional five older children.

The decision to expand, she says, was prompted by the fact that she has already turned away two children — ages 7 and 9 — because her present home is equipped only for infants and toddlers.

The house was donated to the Colette Marie Home by friends on the condition that she pay moving costs. So far, $21,000 of the $25,000 needed has been raised through private donations.

If things continue as they have, raising the last $4,000 shouldn't be too difficult. "Everything's been falling into place. We haven't had to really go out and find (money)," she says, adding that from the start donors have been incredibly generous. For instance,

Some parents abandon their children, but others get too sick to care for them.

she says, one time a woman called her to say that the Colette Marie Infant Home was to receive a $25,000 donation. Gauchat, sure that the money was meant for Our Lady of the Wayside Home, which is right next door, told the woman she must be mistaken. She wasn't. It was given to The Collette Marie Home to help pay day-to-day expenses.

Another woman, Gauchat says, sent a check for $10, explaining that her name was the same as Gauchat's daughter — Colette Marie. When Gauchat looked at the check again, she realized it was for $10,000.

While the overwhelming majority of this tiny community (pop. 7,500) is very supportive of Gauchat, there are some that are wary of bringing children with AIDS to Avon. One incident particularly disturbs Gauchat. At a recent planning commission meeting, where her request to move the second house onto her

Photo by Craig Orosz, The Journal, *Lorain, Ohio.*

A social worker said Prince (right) "looked like a little bird that fell out of the nest."

property was approved, an Avon firefighter voiced his concern by saying, "We have to deal with enough threats of getting AIDS in our everyday work with the public. If you bring these infants into our community, the risk becomes greater. Why do you want to import this problem into Avon?"

"I was really surprised that the firemen were the ones who were really concerned," Gauchat says quietly, "that they were not more knowledgeable" about how AIDS is transmitted. But, she is quick to add, the majority of the community has been very supportive.

For now, Gauchat is content to see to it that Prince and Jeremy are cared for and their needs met. "Right now there are no symptoms, and by that I mean that they are not sick with it," she says, adding that Prince has been selected to receive AZT soon. In fact, she says, before she got Prince, "A social worker called and said he looked like a little bird that fell out of the nest." Back then, Gauchat says, "He was thin and listless." But today, "(The doctors) are amazed to see how well he's doing."

But Gauchat also realizes that unless they return to their families, Prince and Jeremy will likely die at Colette Marie Infant Home. "We're talking about kids who are going to die," she says. "For now we just want to enrich their lives. We want to make them happy and comfortable." — *Michelle J. Carlson*

Clinic to study pediatric AIDS cases

The Cleveland Clinic Foundation, in an effort to expand our knowledge of AIDS, will begin a six-year study next year of children with AIDS.

The clinic was able to secure a $2.9 million grant from the National Heart, Lung and Blood Institute in order to establish a Clinical Coordinating Center, which will monitor patients with AIDS at six hospitals nationwide.

According to James M. Boyett, PhD, the study's principal investigator, "As the Clinical Coordinating Center, we will be responsible for leading the design of the study, training the staff who will be conducting the study, collecting and analyzing data and generating reports and publications." The Clinical Coordinating Center is made up of 22 members and includes one of the country's leading pulmonary neonatologists, Richard J. Martin, MD, who is co-director of the Division of Neonatology at Rainbow Babies and Children's Hospital.

Rosemary Halun, of the clinic's Department of Media Relations, says that "The study came about because of an awareness by NIH (National Institutes of Health) that we have a problem with AIDS and children. It's just an awareness by the government."

According to Douglas S. Moodie, MD, deputy director of the study and chairman of the foundation's Pediatric and Adolescent Medicine Department, heart and lung complications in pediatric HIV-infected patients are not well understood. "That's why this study is so important," says Dr. Moodie. "And it will become even more significant with the growing incidence of HIV infection in women of childbearing age."

OHIO MEDI-SCENE

Clinic to study pediatric AIDS cases . . . *continued*

The clinic expects to study 900 to 1,080 children with AIDS during the course of the study. Infants who test positive for the HIV virus will account for half of the study's patients, while 25% will be children with AIDS and 25% will be a control group made up of infants born to mothers who have a high risk of contracting the HIV virus. (The latter group includes women who have repeated sexual contact with bisexual or homosexual men or who use intravenous drugs.)

Mothers who are HIV positive have a 30% chance of transmitting the virus to their unborn children.

Mothers who test positive for the HIV virus have about a 30% chance of passing the virus on to their unborn children. Of those who test positive for the virus, 70% will develop AIDS and of those, 70% will die within three years.

"What they're hoping to eventually come to," says Halun, "is to draw some conclusions about making diagnoses in utero . . . it'll mean a better quality of life for these children."

Adds Dr. Moodie: "The information that we obtain from this study may chart the direction for the future of pediatric AIDS research. For example, prenatal studies may be possible to detect the presence of the virus at an early stage.

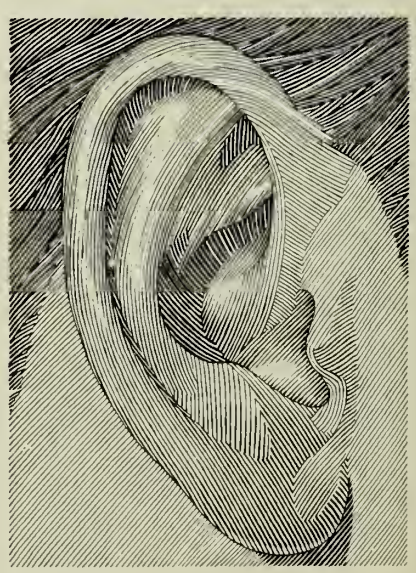
"We are hopeful," he continues, "that we will have the opportunity to change the pattern of course of the disease and perhaps even speed up the development of improved testing and drug therapies."

The foundation will receive daily information about each patient on a daily basis from the participating medical centers via a computer and electronic mail system. Participating hospitals are: the University of California in Los Angeles; the University of California in San Francisco; the Baylor College of Medicine in Houston; Children's Hospital Corp. of Boston; and the Mount Sinai School of Medicine and Columbia-Presbyterian Medical Center, both in New York.

Ohio hospitals were not included in the study, Halun says, because "There are probably only about 28 cases (of children with AIDS) in the state and you have to have enough cases" to form an accurate study. — *Michelle J. Carlson*

Ohio milestones: Ohio's medical community stays poised on the profession's cutting edge

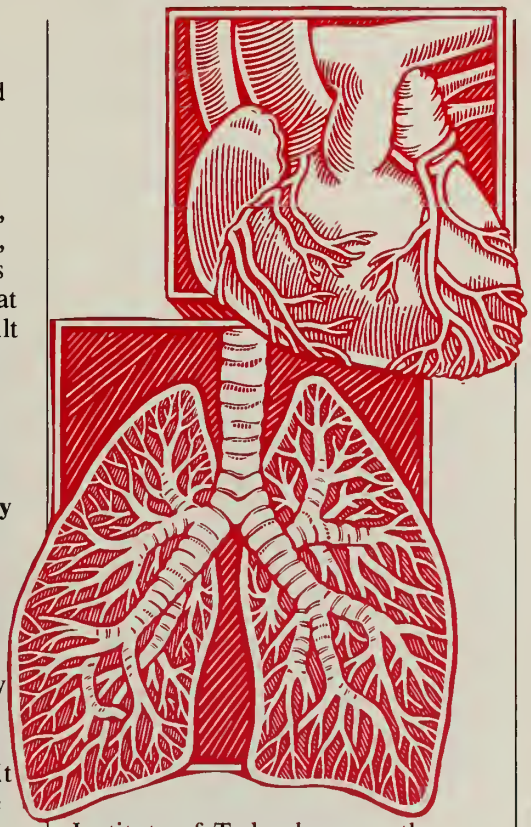
• **Congenitally deaf patient receives cochlea implant** . . . While the miracle of cochlea implants has been in existence for several years now, its use in deaf-from-birth patients has been strictly limited by the Food and Drug Administration, as has the implant surgery itself. Cincinnati surgeon Claude P. Hobeika, MD, and Bethesda North Hospital (Cincinnati) are among only 20 programs in the U.S. to have FDA approval for performing the experimental implants. Early this summer, Dr. Hobeika implanted one of the so-called "bionic ears" in 22-year-old congenitally deaf patient Birtha Deborah Adkins of Floyd County, Kentucky. Adkins is one of only about 30 deaf-from-birth patients in the country to receive the implant. According to



reports in the *Cincinnati Post*, Adkins' reaction was subdued when the implant was first turned on. But, "you could see it in her eyes something was different," Adkins' mother was quoted as saying. With the implant in place, Adkins must now learn to receive, process and interpret sounds she's never heard before — a lesson that is apt to prove frustrating, difficult and complex, points out Dr. Hobeika. But then, what price miracles?

• **Test for heart abnormalities may be improved** . . . A University of Cincinnati cardiologist, Myron Gerson, MD, and a professor of chemistry, Edward Deutsch, have begun preliminary steps toward testing a new compound that may make it easier to detect heart abnormalities. The compound, developed by Deutsch as the result of a 13-year study to find a more effective way to show impeded blood flow to the heart, is an isotope, based on technetium 99m. While two other compounds, developed by Deutsch, failed to be practical in clinical trials, technetium 99m looks to be promising, Deutsch reports. If successful, the new compound may be used in a test that could replace the costlier, riskier and more uncomfortable angiogram. Once FDA approval has been given, testing will begin on approximately 35-40 Cincinnati-area patients.

• **Research Bonanza** . . . The University of Cincinnati Medical Center was recently awarded a seven-year, $16.5 million Programs of Excellence grant from the National Heart, Lung and Blood Institute — one of only six or seven grants that will be distributed nationally by this group. (UC and the Massachusetts



Institute of Technology are the only centers to receive grants so far.) The monies will be used to pay for research into the genetic and molecular causes of heart and lung disease, as well as the study of the structure, genetic regulation and role of proteins necessary to heart and lung functions, UC officials report. According to a *Cincinnati Enquirer* article, the university selected seven areas last year in which they thought the center could excel, and cardiovascular research was one of those areas. Prior to receiving the grant (awarded by Claude Lenfant, MD, Director of the Institute and designer of the Programs of Excellence grants), Jerry Lingrel, director of the medical center's department of molecular genetics, biochemistry and microbiology said, "We want (Lefant) to go away with the idea that we are deserving and that we are on the cutting edge of science . . . "

• **Cancer tracking system in place** . . . Government and health-care leaders in northeast Ohio have joined forces to expand the area's current cancer tracking system. The new cancer registry will enable physicians, researchers and hospitals to track the geographic and demographic patterns of cancer and to assess different types of cancer treatment.

The state's first population-based cancer registry has been on the drawing board for 14 years and was established with matching grants from Cuyahoga County and the state.

The current hospital cancer registry, Cancer Data System (CDS), tracks about 75% of cancer cases in the area, but is unreliable for an area-wide data base, explains Robert Kellermeyer, MD, a CDS board of trustees member and director of the Ambulatory Unit at the University Hospital's Ireland Cancer Center.

Researchers will track cancer rates among blacks in the Cuyahoga County area.

One aspect health professionals will be monitoring is the high incidence of cancer among blacks in the Cuyahoga County area, Dr. Kellermeyer points out.

The expanded tracking system should make Cleveland "a leader in this effort, considering that there are only a handful of metropolitan areas across the country with population-based systems," points out State Rep. Jane Campbell, who pushed for funding for the registry.

According to a Greater Cleveland Hospital Association source, the state is also considering development of a statewide tumor registry. — *Journal staff*

OHIO MEDI-SCENE

Team physicians honored

The following six physicians have been named the 1989 "Ohio Outstanding Team Physicians" by the Joint Advisory Committee on Sports Medicine of the Ohio State Medical Association and the Ohio High School Athletic Association:

W.K. Cotton, MD, for 31 years of service at Lake High School in Uniontown

W. Paul Kilway, Jr., MD, for 29 years of service at Walsh Jesuit High School in Stow

Jack L. Litle, DO, for 24 years of service at Franklin High School in Franklin

William E. Moats, MD, for 27 years of service at Revere High School in Richfield

David S. Palmstrom, MD, for 20 years of service at Ravenna High School in Ravenna

William T. Wright, MD, for 34 years of service at Spencerville High School in Spencerville

Awards were presented in July during the annual Ohio High School Football Coaches Association Hall of Fame Banquet in Canton.

Award presenters included Michael J. Vuksta, MD, Chairman of the Joint Advisory Committee on Sports Medicine of the OSMA, Ohio High School Athletic Association and Ohio Athletic Trainers Association; Robert C. Erickson II, MD, Massillon, a member of the Awards Subcommittee; and Richard L. Armstrong, Commissioner of the Ohio High School Athletic Association. The OSMA honored Armstrong, who is retiring at the end of 1989, with a special award for his contributions to sports medicine.

". . . I know of few things better than athletics to teach young people how to perceive and approach life."

Jack L. Litle, DO, Franklin

"The rewards I have received have been rewards of satisfaction in being a part of the team. The agony of defeat will many times make the joy of victory so important."

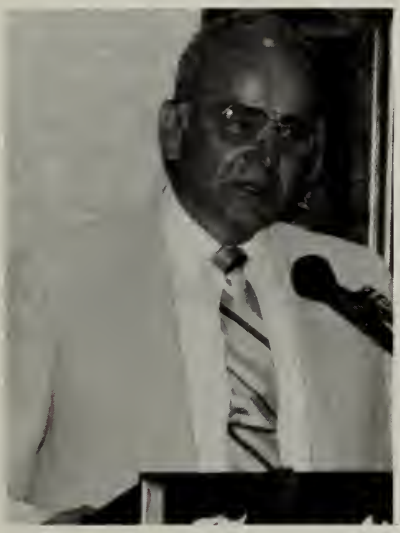
W. Paul Kilway, Jr., MD, Cuyahoga Falls

1989 Ohio Team Physicians

Photos by Tom Lazaroff, Massillon

"It's great to be able to help the athletes and coaches in the prevention of injuries as well as the evaluation and treatment."

David S. Palmstrom, MD, Ravenna



"The spirit of teamwork and cooperation learned on the playing fields carries over throughout one's life to help one deal effectively with challenges in personal, work and social situations."

William T. Wright, MD, Spencerville

"My past experiences and the cooperation and appreciation of the players and coaches continue to kindle the flame of interest, and will bring me back again next year."

William E. Moats, MD, Akron

"Being associated with these dedicated young people and watching as they and their coaches worked to mold an effective playing unit has been enjoyable . . . It has helped to keep me young at heart . . ."

W.K. Cotton, MD, Hartville

OHIO MEDI-SCENE

Hospital vogue

Evening year . . . day year . . . In a recent fast-food commercial, this is the way an emcee with an exaggerated Russian accent introduces the latest fashions. The point is that there's nothing very appealing about an uninspired and unvarying wardrobe.

This fashion sense hasn't been lost on designers at Riverside Methodist Hospital in Columbus who believe there's room for improvement in the current hospital garb.

The current gown du jour leaves a lot to be desired and little to the imagination. Says Riverside President Erie Chapman III, "The patient gown is the ugliest garment ever made."

Chapman says many people have come to expect hospital wear to be "one of the insults" of their hospital experience. Sometimes he'll hold up a gown during a speech and say, "There's one other thing that happens to you" during your visit, to which audiences always respond knowingly and sympathetically, he says.

A sampling of the new gown designs in the works at Riverside Methodist Hospital in Columbus.

"A little piece of cloth on a 6'3" guy doesn't work too well . . ."

With patients receiving visitors during their hospital stays, a gown with a little more style and substance would probably be highly appreciated. "A little piece of cloth on a 6′ 3″ guy doesn't work too well, and it always opens at the wrong times," Chapman says.

But there is good reason for the loose fit and simplistic line of hospital gowns. Their primary function is not to interfere with the patient's medical care, to make medical care as accessible as possible. After all, it's unrealistic for patients to lounge around in gowns with several rows of buttons and elastic at the sleeves.

But perhaps there is a happy medium between a *functional* and *fashionable* hospital gown . . . a gown that isn't difficult to get on and off, for example, but one that has more style than a sheet with arms.

A newly designed gown that has been getting positive feedback from patient models is a one-size-

fits-all wrap-around that ties inside and out and has large sleeves and pockets. Proposed colors for the gown include pink, light grey and blue.

Another gown design is fashioned in the style of a Japanese kimono, while another features a scoop neck and pleated waist. When designing different styles, gown designers consider the special needs of patients, such as those in maternity and intensive care wards.

Chapman says he likes the idea of giving people a choice . . . He hopes to be able to offer patients up to four different designs. Some of the gown styles are already available.

A recent article reported that the updated look on the floors of the hospital will cost a little more. But who knows? Riverside Hospital may end up having the best looking gowns in the business. — *Deborah Athy*

Heimlich helps oxygen-dependent patients

Patients dependent on oxygen therapy may soon breathe easier thanks to Micro-Trach, a new portable device developed by Cincinnati thoracic surgeon, Henry Heimlich, MD.

The device consists of a narrow breathing tube, as wide as the lead in a pencil, which is inserted under local anesthesia through a puncture at the base of the neck and into the trachea. By bypassing dead air space in the nose and throat, patients using Micro-Trach need only one-quarter to one-third the oxygen needed when treated through a nasal tube.

In a paper published in the May issue of *Chest,* Dr. Heimlich says 80% of the first 200 patients to use the new method continued to use it for at least three years. In seven years of clincial experience, he continues, there have been no serious complications.

COLLEAGUES

RICHARD F. SHONK, MD, Lancaster, has been appointed medical director at Lancaster Fairfield Community Hospital . . . **SHELDON ARTZ, MD,** Orange, has been elected president of the Center for Plastic Surgery in Beachwood . . . **JAMES KVALE, MD,** Youngstown, has been named medical director at Park Vista Retirement Community . . . **ROBERT MCMASTER, MD,** Cincinnati, has received the Distinguished Service Award of the American Heart Association's Ohio Affiliate . . . **WILLIAM SMEAD, MD,** Columbus, has been appointed chief of staff of the division of neurosurgery at Ohio State University Hospitals . . . **RAY W. GIFFORD, MD,** Cleveland, has received two awards recently: the Physician Marketer of the Year by the Society for Healthcare Planning and Marketing of the American Hospital Association; and the National Health Professional of the Year Award by the Visiting Nurse Association of Cleveland . . . **ROBERT LERNER, MD,** Cincinnati, has been appointed medical director of geriatrics at The Jewish Hospital . . . **PETER MARROCCO, MD,** Cincinnati, has been elected to serve on Indian Hill's Community Chest Board of Trustees . . . **TOM E. PAPPAS, MD,** Westerville, has received the Medical Assistant Boss of the Year Award from the Columbus and Franklin County Academy of Medicine . . . **JEFFREY SCHNEIDER, MD,** Cincinnati, has received the Blankenhorn Society Award for his excellence in the teaching of internal medicine. The award is given by the Department of Internal Medicine at the University of Cincinnati Medical Center . . . **J. KEVIN AHERN, MD,** Centerville, has been named Intern of the Year at Miami Valley Hospital . . . **TED A. HECKENDORN, MD,** Marion, has been elected president of the Marion Academy of Medicine for 1989-90 . . . **RICHARD E. BEHRMAN, MD,** Gates Mills, has received the 1989 Maurice Saltzman Award in recognition of his enhancing the quality of medical education and research at Case Western Reserve University School of Medicine . . . **MICHAEL DEVEREAUX, MD,** Cleveland, has received Case Western's second annual Faculty Teaching Excellence Award . . . **LOUISE KEATING, MD,** Cleveland, has been awarded the Charles R. Drew Award from the American Red Cross National Headquarters. The award is given each year to a volunteer or employee who has made an outstanding contribution to improving blood services . . . **RICHARD N. HIRSH, MD,** Akron, has been named Member of the Year by the American Physicians Fellowship for Medicine in Israel . . . **RICHARD GORDON, MD,** Springfield, has received the 1989 Teaching Excellence Award at Wright State University School of Medicine . . . **HAROLD BARKER, MD,** Cleveland, has received the Edward F. Meyers Outstanding Trustee Award at St. Alexis Hospital . . . **WILLIAM ABRAMSON, MD,** Dayton, has received the Professional Excellence Award from the Wright State University Academy of Medicine . . . **MARY LOU ZWIESLER, MD,** Dayton, has received the 1989 Outstanding Resident Award from Wright State University Academy of Medicine . . . **WILLIAM HALL, MD,** Columbus, has received the first Bill Hall Award for Service to Ohio Chapter ACEP from the American College of Emergency Physicians . . . **JESS YOUNG, MD,** Cleveland, has been elected the first president of the newly established Society for Vascular Medicine and Biology . . . The Cleveland Society of Obstetricians and Gynecologists recently elected its 1989-90 officers. They are: **MICHAEL GYVES, MD,** Cleveland, President; **GITA GIDWANI, MD,** Fairview Park, President-Elect; and **ALEXANDER W. KENNEDY, MD,** Cleveland, Secretary . . . **FRANK R. NOYES, MD,** Cincinnati, has received the University of Cincinnati Award for Excellence in recognition of his research leading to advances in the understanding and treatment of knee ligament injuries . . . **THEO F. CLASSEN, DO,** Chagrin Falls, has received a three-year appointment as cancer liaison physician at Brentwood Hospital in Cleveland and **ANGELO J. DEMIS, MD,** Alliance, has received an identical appointment at Alliance Community Hospital.

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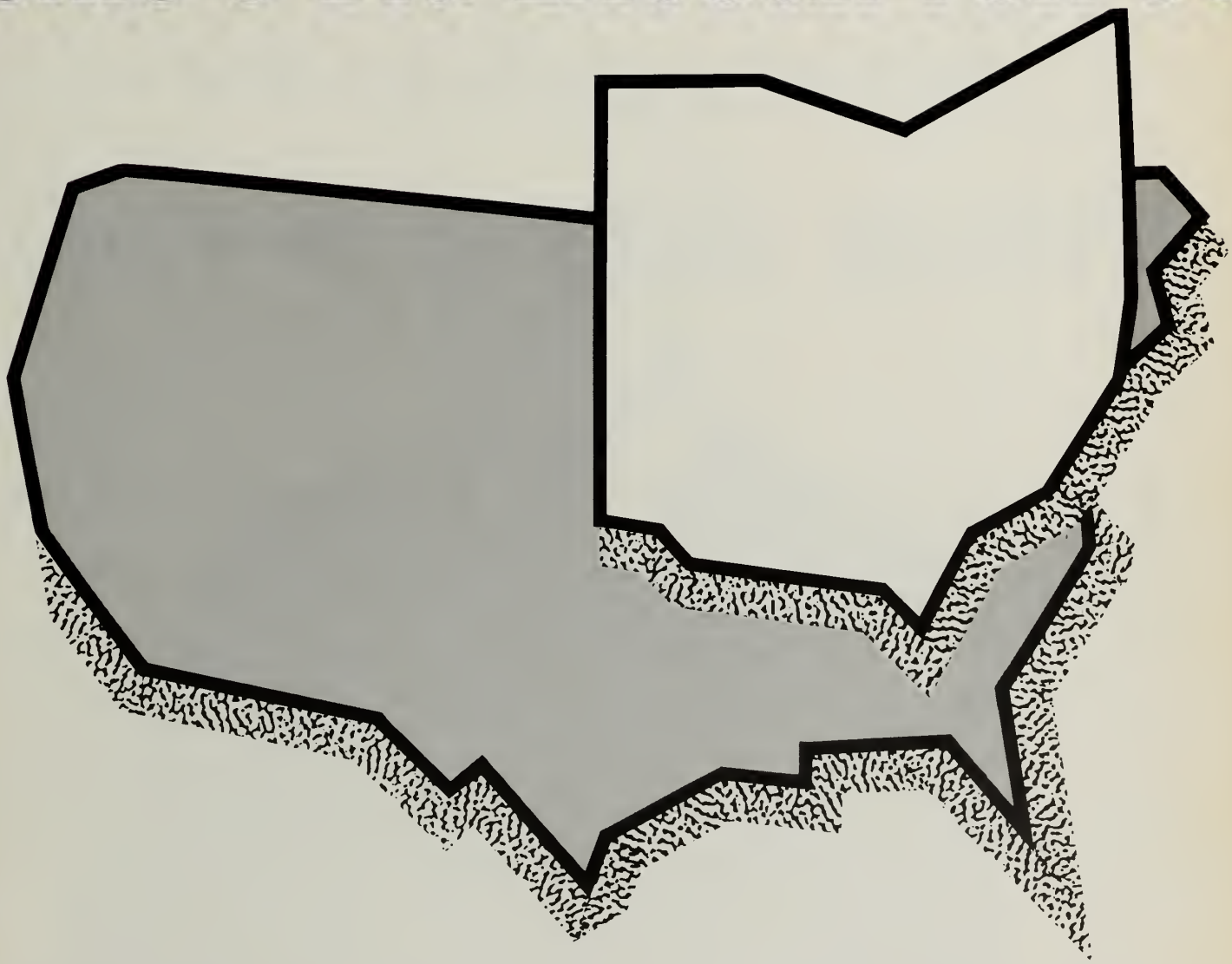

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Editor's Note: *The OSMA has not taken a position on the use of private judges in professional liability cases. Physicians should talk with their defense counsel and abide by his or her recommendation.*

Private Judging in Ohio

By Judge Lawrence Grey

It is hard to write an article about a significant change in Ohio law when Judge Wapner is the best example of what one is talking about. But to understand private judging, Judge Wapner is the best place to start.

Several years ago California adopted a system of private judging whereby the parties to a lawsuit could hire a retired judge to hear their case. Some sharp T.V. producer saw an opportunity, created "People's Court," and hired Judge Wapner, who used to be a trial judge, to be the star of the show. This show is syndicated in dozens of media markets, and Judge Wapner is a celebrity.

If you listen to the announcer at the beginning of "People's Court," you will get a good idea of how the whole thing works. He says that the parties have agreed to let Judge Wapner decide their case and to be bound by his decision. Private judging in California is as simple as that. Ohio is not California, but private judging in Ohio is just about as simple.

Ohio has dozens of retired judges, some beyond the mandatory retirement age, and others who have voluntarily retired. Under the Ohio constitution, the Chief Justice of the Ohio Supreme Court can appoint a retired judge to handle a case. Often this is done where there is a potential conflict of interest. For example, when a court employee is getting a divorce, a retired judge from another county may be appointed to avoid any claim of favoritism. Retired judges are sometimes appointed when the case is a political hot potato, like an abortion case. The parties might feel that since a retired judge doesn't have to worry about getting re-elected, he will be impartial. Retired judges are also used to help out a sitting judge who gets ill or gets three death penalty cases in a row, and falls behind in his caseload.

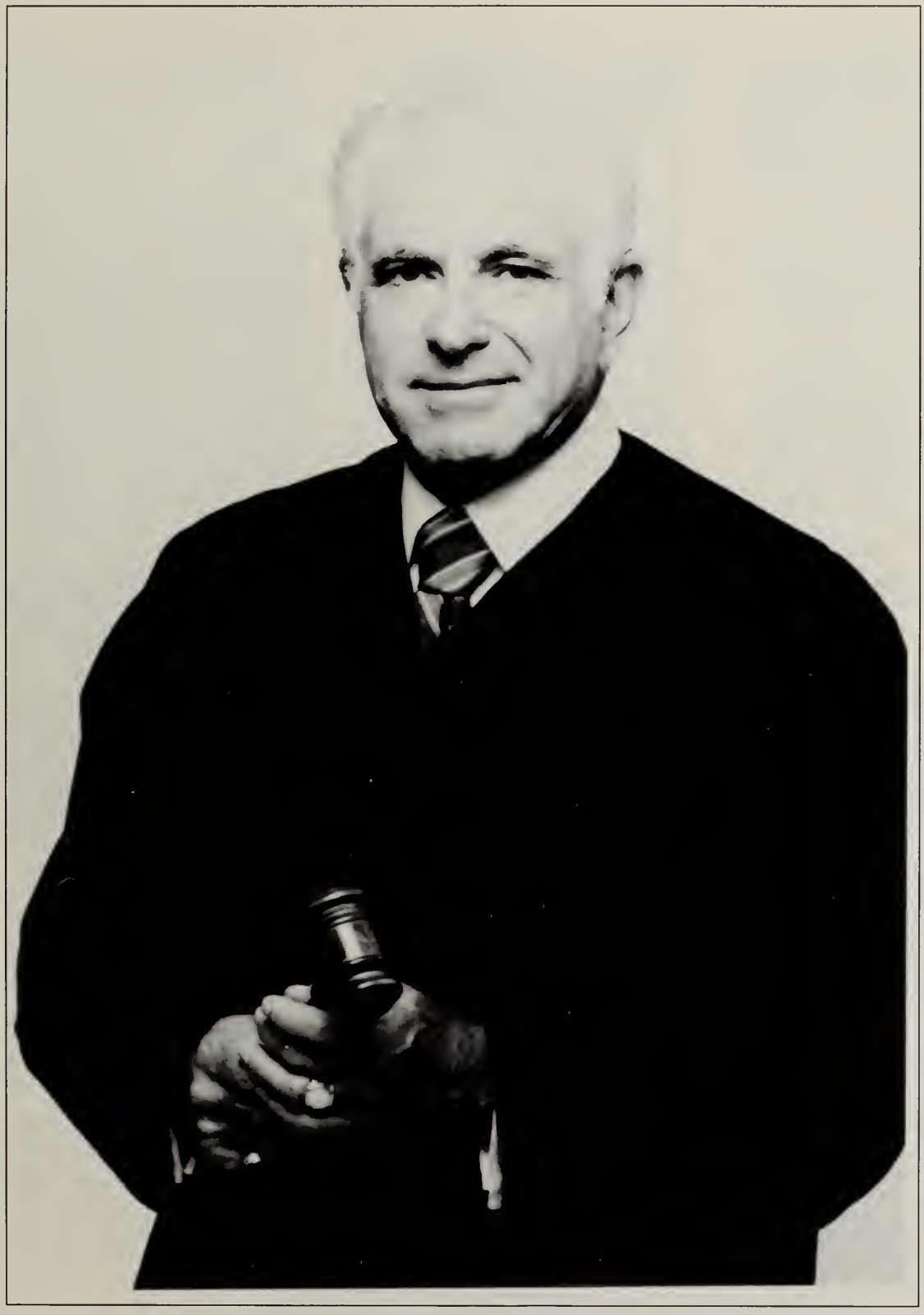
Private judging may be of particular interest to physicians in the area of malpractice.

Private judging is nothing more than an extension of the work retired judges now do, but instead of the retired judge being asked to handle a case by the Chief Justice, the parties themselves pick a judge and ask the Chief to appoint him to their case.

Private judging may be of particular interest to physicians because there are some advantages to it over ordinary legal procedures. For example, in some cases speed is quite important to the parties. When I served on the Supreme Court committee that was preparing the private judging rules, I called an appeals judge friend in Los Angeles and asked him how it was working out there. He told me of a case where two developers owned adjoining property, but there was a question about where the property line really was. Neither party was concerned about the line because its location would not affect their building plans, but neither could get financing until the discrepancy was resolved. By going to a private judge, they got the case decided in about three weeks.

My friend also told me that celebrities like to use private judging for their divorces because it eliminates a lot of publicity, and that it is occasionally used in divorce cases in small towns where people want to maintain a bit of privacy.

One area of private judging



AP/World Wide Photos

Judge Joseph Wapner, who dispenses televised justice on "The People's Court," is one example of private judging.

which is of particular interest to physicians is malpractice. My Los Angeles friend told me of a judge who, as a practicing attorney, had extensive experience in malpractice cases. He worked for 10 years or so for one of the big defense firms, and then opened his own practice and did another 10 years or so as plantiff's attorney. He was appointed to the appellate court but found the work boring, so when private judging was adopted he resigned and started doing private judging. Because of his extensive experience on both sides, his knowledge of medical practice, and his reputation as being fair, he has more work than he can handle.

Perhaps this is a good place to explain how private judging works. First of all, private judging is not arbitration. Private judges are really judges who exercise the same kind of authority as sitting judges. Their orders are enforceable by contempt, their money judgments can be executed on by foreclosure, and one can take a direct appeal from their decisions to the appellate court, as one could in any other court decision. However, private judges are not bound by the ordinary rules of procedure and evidence if the parties agree to something else. For example, a case could be submitted entirely on the depositions if the parties agree to that. Or an asbestosis case might be submitted by giving the judge the entire medical record, the estimates of disability, the wage information about the plaintiff, life expectancy, etc., and allowing him to reach a decision based on all documentary evidence without taking any oral testimony.

Under private judging, anything the parties agree to is permissible. Obviously, substantial saving in time and money can be achieved by using a private judge and agreeing to simplify the process.

A retired judge who wants to do private judging puts himself on a list. His name is given to anyone who requests it, along with his resume so the parties have some idea about his background. The parties agree on a judge, and if he is willing, request that the case be assigned to him. The private judge then consults with the attorneys and sets the ground rules, such as when and where the evidence is to be submitted. They must also decide on the judge's fee because the private judge is paid by the parties. Retired judges assigned to a case on the regular docket get the same per diem as a sitting judge, from $205 to $225 depending on the court.

After the case is submitted, the judge makes a decision and his judgment is entered with the Clerk of Courts, and the case is over.

This is a fairly simple process, as are most things in the law when the parties can agree, and has some real advantages for physicians. First, there is knowledge. A physician-defendant might feel more comfortable having his case decided by a judge who has had a lot of experience with medical issues, and who is less likely to be swayed by emotional appeals. A patient-plaintiff might want his case tried by a judge who is known for his fairness. And both parties may prefer to have the case decided by a private

judge who can reach a decision much more quickly than a sitting judge who has 100 other cases ahead of theirs.

Private judging will not benefit just physicians, of course. In a trade secret or patent infringement case, a private judge can take evidence in private so as to protect the secret. In an aviation case, a judge who was a Navy pilot and then flew for a commercial airline might be the best choice as a trial judge. In medicine, the hard cases tend to get assigned to the specialist because of his superior knowledge in the field. Private judging allows the case to be assigned to a judge who may have superior knowledge.

There is one criticism of private judging which has some validity. People who can afford to hire a private judge get their cases decided quicker. This is, to some extent, unfair to the people who have to wait their turn in line in regular court. On the other hand, cases assigned to private judges are more likely to be those that are complex and that will require a lot of a judge's time. When some of these cases are removed from the ordinary docket, the sitting judge will have more time to devote to his regular cases.

Private judging is a new procedure, and in the law as in medicine, it always takes a while for a new idea to be accepted. I anticipate that it will be a while, but that in five or 10 years private judging will be a common practice. When I retire, I think I might like to try it. Being a judge is a hard way to make a living, but trying a case every now and then would make retirement much more interesting. **OSMA**

Lawrence Grey, JD, is Judge for the Fourth Appellate District Court in Athens and is a frequent contributor to **OHIO Medicine.**

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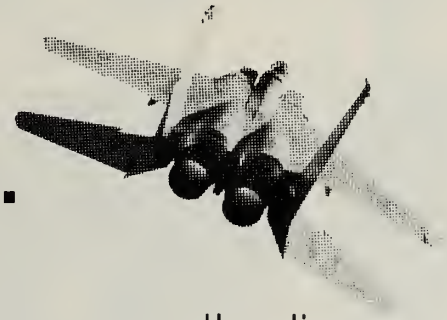

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AIR FORCE

Are steroids muscling in on your patients?

By Michelle J. Carlson

"You see somebody in the gym and you want to be like them and you don't want to work out for seven years to do it . . . You see what it can do and it just blows your mind."

"When you start bloating up, you have that feeling like . . . everything is so tight. You can lift incredibly strong. You have that drive."

— Excerpted from *The Cleveland Plain Dealer*

Everyone knows the old adage, "You can never be too rich or too thin."

If the saying were changed to "You can never be too big or too strong," it might well sum up the mind-set of the majority of today's high school and college athletes.

To them, bigger is better.

But how they get bigger is fast becoming front-page news. The long-held notion that hard work and perseverance pays off no longer applies. Today, a growing number of high school and college athletes — your patients — are gaining the competitive edge by using a shortcut — anabolic steroids.

According to most studies, anywhere from 6% to 12% of all high school athletes currently rely on steroids. One study, recently reported in the *Journal of the American Medical Association,* estimated that as many as half a million teen-age boys may be using anabolic steroids to improve their athletic performance. While many Americans may find these figures shocking, John A. Lombardo, MD, director of sports medicine at the Cleveland Clinic, calls them predictable.

"I think it's to be expected. The effects of steroids are positive. They do what the athlete wants them to do," he says. "If they go on steroids and end up on the football field, everyone thinks they're great."

Alan H. Rosenthal, MD, a Mayfield Heights pediatrician and director of Mt. Sinai's Sports Medicine Institute, agrees with Dr. Lombardo. "It doesn't shock me, but I think it may get worse," he says, noting that there has been a "marked increase (in use). It's hard to put numbers on it because it's a secretive thing. No one comes out and says, 'I'm doing steroids.' "

Medically, steroids do have legitimate uses — such as treating trauma and burn patients — though Dr. Lombardo hastens to add that most therapy is short-term.

But, Dr. Lombardo says, when

using anabolic steroids for extended periods of time, "the liver is affected, but the incidence of that is low, (there are) changes in the metabolism of the liver. Psychologically, people have mood swings . . . they become more aggressive . . ."

Most of the side effects, he continues, are reversible, "but some aren't. Acutely, the thing you're worried about is the mood swings. Long-term, you worry about cardiac trouble."

Again, Dr. Rosenthal agrees, saying that aggression is the biggest concern. "Those are not easy years (the teens), then you introduce something that produces marked (psychological) changes."

Despite the health concerns, Dr. Lombardo says he's convinced teen-agers will continue to use steroids.

"The physical risks — most of these people don't look at it that way. They're teen-agers, they think they're invincible. I don't think that the physical dangers are enough for them to stop taking them."

That's not to say that teens aren't aware of the dangers, he continues, but when cases of undesirable side effects happening are so few and far between, it does little to deter them.

"(The side effects) are real," says Dr. Lombardo, "but you're not talking one in two (people are affected), one in 10, one in 100 . . . one in 100,000. You're going to tell them these things are scary? Is the number, the quantity of these things happening, is it enough to tell them not to use it?"

Dr. Lombardo takes a moment to compare one evil — taking steroids — with another — alcohol abuse. Every day, hundreds of thousands of Americans engage in a practice that endangers their health and is potentially fatal. The danger of drinking and driving is clear and present, the statistics well documented — and yet, people still drink and drive.

In other words, if hundreds of thousands of people continue to drink and drive even though they know the statistics, how can we expect to convince teen-agers to stop taking steroids when their use doesn't appear to be nearly as life-threatening?

Another point Dr. Lombardo makes is that unlike alcohol and most drugs, steroids produce desirable physical results.

"Acutely, the thing you're worried about (with steroids) is . . . mood swings. Long-term, you worry about cardiac trouble."

"If you come into the office drunk, everyone calls you a drunk," he says, "but if you come in and have all these muscles," you receive positive reinforcement for using steroids.

Lest you think Dr. Lombardo is an advocate of steroid use among teens, rest assured that he is very much against it.

"My whole thing is that this (steroids) is wrong," he says. "Psychologically, it sets them up for a pill-taking mentality and it doesn't let them face their limitations. My thing against them is sociologically . . . they don't allow fair play."

How does Dr. Lombardo broach the problem if he suspects a patient is taking steroids? He usually doesn't.

"If someone comes in for a hang nail, I don't ask them if they're taking steroids," he says, "but if an athlete comes in with a torn muscle, I have to know" if they're on steroids.

So far, he's had little trouble eliciting a response.

"Most of them tell *me*," he says, "because they know I'm not a preacher and I'm not going to tell anyone. I offer them the opportunity to talk about it. I ask them what they know about steroids."

Dr. Rosenthal, on the other hand, often sees patients at the insistence of their parents, who suspect steroid use.

"I just had a 14-year-old and a 15-year-old last week that both moms were concerned about, and both kids denied (taking steroids)," he says.

"This one individual had a 35-pound weight gain in a year, had quite a lot of acne . . . was having temper tantrums. I sat down with him and said everything indicated he was on steroids and he vigorously denied it."

After Dr. Rosenthal performed some blood tests that left him "99% sure he was taking steroids," he shared the results with the boy. "He finally admitted it," Dr. Rosenthal says, adding that the patient "had already had some significant changes and he'd only been on them for three or four months."

Usually, Dr. Rosenthal says, it takes time to get a patient to admit to steroid use because they're afraid of being suspended from their athletic team, even though Dr. Rosenthal does not share his patients' information.

"What I do is go through a physical exam and talk extensively about their medical history, and once I've established rapport, I ask them . . . If I bring it up right away, they're not going to tell me."

Getting teens to admit to using steroids and getting them to stop, however, are two different things.

"I'm starting to develop a support group for anabolic steroid users," says Dr. Rosenthal. "I think we really need to do something because I can give him all the warnings in my office, but that's not going to stop him from taking steroids."

Dr. Rosenthal says there are several reasons why teen-agers seem to be taking the drugs in increasing numbers.

"We've done a poor job in educating people and we as physicians have lost our credibility because for years we said steroids don't work. We have to re-establish ourselves with athletes." Professional athletes who succeed while taking steroids can also influence teens, he says.

"They're seeing that these things work," he says, "and (they think) if they can take it, why can't we?"

The availability of and easy access to steroids is yet another factor contributing to their widespread use.

"When I talk to high school teams before the season," says Dr. Rosenthal, "and ask them if they know where to go (to get steroids), probably 90% raise their hand."

And, of course, there is always the competition to consider. "They just don't think (anything bad) will happen to them and they think their competition is using them," says Dr. Rosenthal, who adds that they're also "getting mixed signals from coaches — and I want to make it clear that I'm not blaming them. They're not telling them to take it, but (athletes) get the message that they better be 30 pounds heavier."

But in the final analysis, he says, no individual reason can be blamed for the proliferation of steroid use.

"Everything in society is win, win, win," he says. "It's a societal problem that we all have to be concerned with. I think it's going to take a big effort to curb these things." **OSMA**

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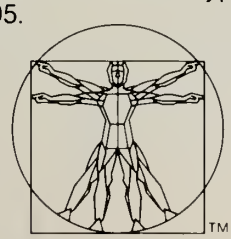

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OHIO STATE MEDICAL ASSOCIATION

Annual Clinical Update
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November 3, 4 and 5, 1989

Dayton Convention Center
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Clinical Update 1989

Something for everyone . . . the 1989 Ohio State Medical Association Clinical Update will cover a complete weekend of medicine.

Do you need your CME hours? Here is your opportunity to attend a wide selection of courses. In addition to a large selection of clinical programs, several programs on how to meet the ever-pressing needs of the business aspects of medicine will be presented; e.g. "How to Run A More Profitable Practice" (a separate mailing to membership in September). This workshop will teach you some practical ways to maximize revenues, reduce overhead and improve bottom-line results.

"Medicare Catastrophic Health Care and Other Current Developments" will help you better understand the role of the Office of the Inspector General relating to general oversight of federal health programs — especially Medicare and Medicaid. Hear it from the Regional Inspector General for Audit and the Regional Administrator.

"News Media Training Seminar" teaches you the rules of the game for conducting a successful news media interview — don't get caught unprepared.

"Court Room Appearances: Tips From a Survivor" will help you should *you* be faced with a courtroom appearance. This is presented by someone who has been there.

The course on "Active Risk Management" will teach you that certain behavior will minimize the risks of legal actions being filed. At the conclusion of the course, "Ethics 101: Application of the AMA's Principles of Medical Ethics," the practitioner will have a better understanding of the ethical guidelines of the AMA.

In addition to this, the Ohio State Medical Association Auxiliary will sponsor a program for spouses on "Why Some Physicians' Widows Face Financial Disaster." This program is conducted on Saturday morning, November 4, by Clayton Scroggins and Associates.

The AIDS Update III: 1989 will start the clinical meeting on Friday morning November 3 at 9 am. Bernie Branson, MD, of Baltimore, Maryland will serve as the keynote speaker. Thomas J. Halpin, MD, Chief, Bureau of Preventive Medicine, Ohio Department of Health, will serve as course director.

Exhibit time is built into the program to allow you time to visit the exhibits — an opportunity for you to contact them in a pleasant, quiet, unhurried atmosphere away from the daily demands of telephones, etc. Lunch on Friday and Saturday is available in the exhibit area.

Make it a weekend. Make your plans to attend now. Check your August, September and October issues of the *OSMAgram* for hotel and registration forms. Make the right decision. Come to Dayton, November 3-5.

The Programs . . .

Editor's Note: *The following is a partial listing of programs that were available at press time.*

FRIDAY

AIDS Update III: 1989
Date: Friday, November 3, 1989
Time: 9:00 AM to 12:30 PM
(½ hr. break 10:30-11:00 AM)
Program Description:

How the physician can work within the community in caring for persons with AIDS and preventive HIV transmission.

Course Director: Thomas J. Halpin, MD, Chief, Bureau of Preventive Medicine, Ohio Department of Health, Columbus, Ohio

Keynote Speaker: Bernie Branson, MD, Baltimore, Maryland

Current Review of TPA Therapy
Date: Friday, November 3, 1989
Time: 2:00 to 3:30 PM
Learner Objectives:

1. To review and understand the current indications for thombolytic therapy with patients with acute myocardial infarction.
2. To assess the indications and late results of such therapy.

Course Director and Speaker:
Patrick L. Whitlow, MD
Interventional & Angiography
Department of Cardiology
Cleveland Clinic
Cleveland, Ohio

Speaker:
Bertram Pitt, MD
Professor of Internal Medicine
Chief of the Division of Cardiology
University of Michigan Medical Center
Ann Arbor, Michigan

Update on Transfusion Medicine
Date: Friday, November 3, 1989
Time: 2:00 PM to 3:30 PM

A discussion of transfusion medicine as it pertains to the primary care physician will include:

1. Transfusion medicine: An introduction
2. What it means to the primary care physician
3. How to prepare my patient for elective surgery and transfusion
4. Treating hemorrhagic shock in the emergency room.

Following this update from 4:00 to 5:30 PM a program titled "Point Counterpoint: Jehovah Witness View of Transfusion," featuring an attorney to discuss legal implications of religious objections to transfusions, a representative of the Jehovah's Witnesses to present their views, and a lecture on options to treat the patient who objects to transfusion.

Course Director: Melanie S. Kennedy, MD, Director, Transfusion Service, Columbus, Ohio

News Media Training Seminar
Date: Friday, November 3, 1989
Time: 2:00 PM to 5:30 PM

This three-hour seminar covers the rules of the game for conducting a successful news media interview. It includes

information on how to prepare for difficult interviews and how to present medical news in an understandable manner. Special attention is given to television news interviews, but the course also covers talk shows and radio and newspaper interviews.

During the course each participant is videotaped doing a mock interview and this tape is critiqued by the instructor. Course enrollment is limited to 15 participants.

Instructors:

Carol Wright Mullinax, Director, Department of Communications, OSMA

Doug Evans, Associate Director, Department of Communications, OSMA

Addiction — The Disease Concept Anthropology and Genetics
Date: Friday, November 3, 1989
Time: 2:00 PM to 5:30 PM

This course is sponsored by the OSMA Physicians Effectiveness Committee and its action arm, the Physicians Effectiveness Program (PEP).

Learner Objectives:

1. The impact of addiction on modern Western culture compared to the impact of the bubonic plague on medieval culture;
2. We will point out the historical development of the health industry in Western culture and the differing roles that have been assigned to it over the centuries;
3. The role of the health industry as the hub of the cultural evolution towards technocracy (with its politics of plenitude and achievement) vs. biocracy (with its politics oriented around human values) will wrap up the program.

Course Director: Edward T. Carden, MD, Cleveland, Vice Chairman, Physicians Effectiveness Committee.

Speakers:

Sean O'Connor, MD, Department of Psychiatry, University of Connecticut School of Medicine, Farmington, Connecticut

Craig T. Pratt, MD, President, Ohio Society of Addiction Medicine; Program Director, Shepherd Hill Hospital, Newark; Member, OSMA Physicians Effectiveness Committee

Chris L. Adelman, MD, Medical Director, Rosary Hall, St. Vincent's Charity Hospital, Cleveland, Ohio

Dr. Carden

Courtroom Appearances: Tips From a Survivor
Date: Friday, November 3
Time: 4:00 PM to 5:30 PM
Learner Objectives:

1. Describe the ideal appearance, posture and demeanor of a physician who appears in court;
2. Realize that all witnesses' credibility and credentials may be challenged;
3. Avoid over- and under-responses to questions placed by opposing attorneys;
4. Avoid becoming defensive;
5. Know how to prepare technical material for the court.

Course Director: Charles F. Johnson, MD, Medical Director of the Child Abuse Program, Children's Hospital; Professor of Pediatrics, Ohio State University College of Medicine, Columbus, Ohio

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Office Management of Patients with Obstructive and Chronic Lung Disease
Date: Friday, November 3, 1989
Time: 4:00 PM to 5:30 PM
Learner Objectives:

Much can be done to improve quality of life of patients with chronic obstructive pulmonary disease.

1. Current assessment of theophylline therapy.
2. Methods of sparing steroid use in airways obstruction.

Course Director: Richard Smith, MD, University of Cincinnati

SATURDAY

HCFA Presentation: Medicare — Catastrophic Health Care and Other Current Developments
Date: Saturday, November 4, 1989
Time: 9:00 AM to 10:30 AM
Learner Objectives:

1. Understand the role of the Office of the Inspector General relating to general oversight of federal health programs — especially Medicare and Medicaid.
2. Awareness of the Office of the Inspector General's action plan for oversight, enforcement and evaluation activities related to the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360).

Speakers:

Martin D. Stanton, CPA,

Regional Inspector General for Audit, HHS/OIG/Office of Audit, Region V, Chicago

Chester C. Stroyny, HCFA Regional Administrator, Region V, Chicago

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How to be a Sports Medicine Physician: The Old "Tape and Go"
Date: Saturday, November 4, 1989
Time: 11:00 AM to 12:30 PM

This course will provide practical tips in the preparticipation exam for student athletes and emphasize proactive measures in the conditioning process to prevent injuries.

Learner Objectives:

1. Provide physician with information to adequately perform a preparticipation physical exam for the pre-teen and teen student athlete in several settings;
2. Enable physician to list disqualifying conditions for sports participation;
3. Enhance physician's basic knowledge for counseling athletes on prevention of injuries through conditioning with emphasis on avoidance of overuse injuries;
4. Give physician practical suggestions for developing a continuing constructive interrelationship with a coaching staff.

Course Director: Leonard J. Janchar, MD, Marion, Ohio

What's New in Pediatric Cardiology
Date: Saturday, November 4, 1989
Time: 11:00 AM to 12:30 PM
Learner Objectives:

Attendees attending this activity will have an increased ability to:

1. Discuss the newer treatment modalities of valvuloplasty and angioplasty;
2. Discuss newer treatments in the dysrrhythmias, including the dive maneuver, overdrive pacemaking;
3. Define the role of Holter/trans-telephonic monitoring in primary care practice;
4. Utilize various cardiologic imaging techniques — MRI and color-flow doppler examination;
5. Discuss the use of fetal ultrasound examination in diagnosing congenital heart disease.

Course Director: Hugh D. Allen, MD, Chief, Department of Cardiology, Children's Hospital, Cincinnati

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Treatment of Fungal Infection in Patients with AIDS
Date: Saturday, November 4
Time: 11:00 AM to 12:30 PM

I. INTRODUCTION
The emphasis on protozoan and viral opportunistic infection in AIDS patients may lead us to neglect common bacterial and fungal infections which cause significant morbidity and mortality among AIDS patients.

II. IMMUNOLOGIC DEFECTS IN AIDS
A. SPECIFIC TO AIDS
1. T cell
2. Macrophage
3. PMN dysfunction
4. B cell
B. NONSPECIFIC IN DEBILITATED HOSTS
1. VIOLATION OF INTEGUMENTAL OR MUCOSAL INTEGRITY
a. Cutaneous ulceration: HSV, Kaposi's
b. IV site sepsis
c. Nosocomial pneumonia
d. Urosepsis
2. PHAGOCYTIC DEFECTS
a. Granulocytopenia
1. Marrow suppression due to HIV
2. Marrow suppression due to chemotherapy
3. Marrow replacement
a. Lymphoma
b. Granulomatous infection
b. Monocyte/macrophage dysfunction

III. COMMON FUNGAL INFECTIONS
A. SUPERFICIAL
1. Mucosal candidiasis
a. An indicator for immunosuppression
b. Oral thrush + dysphagia = esophageal candida = AIDS
2. Onchomycosis: usually symptomatic
B. INVASIVE
1. Cryptococcosis
2. Histoplasmosis
C. TRUISM
1. Tissue diagnosis/invasive tests are needed
a. Serology useless EXCEPT CRYPTOCOCCAL ANTIGEN
b. LP
c. Marrow biopsy
d. Rarely liver biopsy
2. Imaging may be useful

in deciding where to biopsy
a. CT abdominal
b. Head CT/MRI
3. Control, not cure, is the goal with AMB
a. Induction chemotherapy
b. Maintenance chemotherapy
4. Toxicity of therapy often limits therapy
a. 5 FC causes marrow suppression
b. SMB causes its usual toxicities
5. On the horizon
a. Liposomal AMB
b. Fluconazole
c. Itraconazole

IV. COMMON BACTERIAL INFECTIONS
A. NOSOCOMIAL
1. Site related
2. Avoid additional toxicities if possible
B. COMMUNITY ACQUIRED
1. Streptococcus pneumoniae pneumonia
2. Salmonella enteritis/bacteremia

V. CONCLUSION

This extraordinary epidemic has a few redeeming features; it is teaching us to reconsider what were previously thought to be uncommon infections — cryptococcosis, histoplasmosis, disseminated salmonella.

Course Director: Edward L. Goodman, MD, Presbyterian Hospital of Dallas, Dallas, Texas

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Ethics 101: Application of the AMA's Principles of Medical Ethics
Date: Saturday, November 4, 1989
Time: 2:00 PM to 3:30 PM
Learner Objectives:

The presentation will consist of an overview of current AMA activities in the ethical arena including discussion of reports by the Council on Ethical and Judicial Affairs of the American Medical Association. At the conclusion of the presentation the practitioner will have a better understanding of the ethical guidelines of the AMA. In addition, he/she will review selected current activities of medical professionals and see whether these activities fall within or outside the current guidelines. Technical reports of the council and case study examples will be utilized by the presenter.

Presiding: D. Brent Mulgrew, JD, Managing Director, OSMA

Keynote Speaker: Kirk B. Johnson, JD, AMA General Counsel

Orthopedic Sports Medicine for the Primary Care Physician
Date: Saturday, November 4, 1989
Time: 2:00 PM to 3:30 PM
Learner Objectives:

Attending this session should permit the primary care physician to be better able to:

1. Cite four important aspects of physical conditioning;
2. Evaluate and initiate treatment of common sports injuries;
3. Illustrate the pathomechanics of sports injuries;
4. Utilize braces in the prevention of sports injuries.

Attendees to this session are encouraged to bring clinical concerns and problems for discussion, for which ample time has been provided.

Course Director: Mark G. Siegel, MD, Associate Director, Cincinnati Sportsmedicine Center for Orthopaedics

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Infectious Diseases
"Trendy" Infections
Date: Saturday, November 4, 1989
Time: 2:00 to 5:30 PM
Learner Objectives:

This session will present the facts and myths concerning four infections and myths that have recently received much publicity in both medical and nonmedical literature. It is anticipated that the physician will be able to better deal with patients and the many questions about these illnesses after reviewing the current data.

The incidence, pathobiology and treatment of each disorder will be covered and key references will be provided. A question and answer session will be offered at the conclusion of the presentations.

Speakers:

Harrison Bradford Hawley, MD, Director of Medical Education, Good Samaritan Hospital and Health Center, Dayton, Ohio

John Stanley Czachor, MD, Instructor of Medicine, University of Massachusetts Medical School, Worcester, Massachusetts

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Common Office Emergencies
Date: Saturday, November 4, 1989
Time: 4:00 PM to 5:30 PM
Learner Objectives:

1. The attendee will be introduced to the complexities of prehospital medical control.
2. Will know the levels of training

of emergency medical service providers in the state of Ohio.
3. Will understand the methods of response and transport by EMS providers.
4. Will understand the interactions and legal implications between EMS providers and other health-care personnel.
5. Will be introduced to the most common office emergencies prompting call for EMS services, and will understand efficient ways of managing patient care in this setting.
6. Will discuss approach to general emergencies in the out-of-hospital setting.

Speaker:
James J. Augustine, MD, EMS Medical Director, Miami Valley Hospital; Assistant Clinical Professor, Wright State Department of Emergency Medicine, Dayton, Ohio

SUNDAY

Office Otolaryngology for the Primary Care Physician
Date: Sunday, November 5, 1989
Time: 9:00 AM to 10:30 AM
Learner Objectives:
The objective of this course is to update the primary care physician with current management of certain common problems in the office of otolaryngology. Topics to be covered include:
1. Examinations of the eardrum with photographs demonstrating different pathologies of the eardrum.
2. Examination of the nose with stress on the usefulness of the hand-held otoscope and treatment and management of common causes of nasal obstruction including allergic and nonallergic rhinitis.
3. Approach to diagnosis of common head and neck lesions with emphasis on proper examination of lymph node drainage.

At the end of the course, the practicing physician should be able to differentiate common forms of middle ear disease, effectively diagnose and manage nasal obstruction and clinically evaluate lumps and bumps in the head and neck region.
Course Director: Robin T. Cotton, MD, Professor of Otolaryngology and Maxillofacial Surgery, University of Cincinnati College of Medicine; Director, Department of Otolaryngology and Maxillofacial Surgery, Children's Hospital Medical Center

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Active Risk Management ("How Does the Primary Care Physician Manage Legal Risk in a Litigious Environment")
Date: Sunday, November 5, 1989
Time: 9:00 AM to 10:30 AM
Learner Objectives:
1. The physician will understand that certain behavior will minimize the risks of legal actions being filed.
2. The physician will understand that oral statements and medical records become potential evidence in legal actions, and being able to properly control both areas minimizes risks.

3. The physician will understand that there are certain activities that will minimize risks after a lawsuit has been filed and a legal defense is being prepared.
4. The physician will understand that certain mandatory reporting mechanisms at state and federal levels are being instituted to monitor physician activity and it is important that the physician has some input in this process because of adverse effects that could result.

Course Director: Gary R. Harris, JD, Director of Risk Management, University of Cincinnati Medical Center

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Office Management of Arthritis
Date: Sunday, November 5, 1989
Time: 9:00 AM to 10:30 AM
Sponsored by an educational grant from Smith-Kline Laboratories.
Learner Objectives:
The participant-physician, following attendance at this educational activity, should be better able to:
1. Identify newly released non-steroidal anti-inflammatory agents used in the management of arthritis;

2. Discuss the newly revised Food and Drug Administration (FDA) warning label relating to non-steroidal anti-inflammatory agents with attention to decreasing practitioner liability in the use of these agents;
3. Recognize, monitor and treat potential adverse gastrointestinal side effects of non-steroid anti-inflammatory agents used in the treatment of arthritis, including: ulcers, the asymptomatic patient with Guaiac-positive stools;
4. Properly recognize rheumatoid arthritis for the purpose of early interaction;
5. Cite newer treatment options for the management of rheumatoid arthritis.

Course Director: Seth M. Kantor, MD, Assistant Professor of Medicine, University Hospitals Clinic, Columbus, Ohio

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Office Ophthalmology for the Primary Care Physician
Date: Sunday, November 5, 1989
Time: 11:00 AM to 12:30 PM

Participating physicians are encouraged to bring problem cases to the interactive educational session. Cognates to be covered are management of diabetic retinopathy, common ocular infectious diseases and injuries.

Learner Objectives:

1. Participants will be able to recognize and appropriately treat common eye infections and injury.
2. Participants will understand the naural history of diabetic retinopathy and the appropriate times for intervention in an effort to prevent blindness.
3. Common children eye problems and geriatric ocular complaints will be reviewed so that participants will be able to treat, refer and advise patients and their families appropriately.

Course Director: Carol R. Kollaritis, MD, Eye Institute of Northwestern Ohio, Toledo, Ohio

continued on page 790

1989 OSMA CLINICAL UPDATE REGISTRATION FORM

Dayton Convention Center/Stouffer Center Plaza Hotel
November 3-5, 1989

Name _____

Address _____

City, State, Zip _____

Home Phone ( ) _____ Business Phone ( ) _____

My spouse will accompany me. Name _____

TUITION SCHEDULE FOR COURSES

Please indicate membership status and total number of credit hours:

☐ OSMA Member	$10 per credit hour	X _____	= $ _____
☐ Non-Member	$13 per credit hour	X _____	= $ _____
☐ Retired Member	$ 7 per credit hour	X _____	= $ _____
☐ Resident Member	$ 4 per credit hour	X _____	= $ _____
☐ Medical Student Member	$ 3 per credit hour	X _____	= $ _____

Luncheon for registrants for courses only: NO FEE
Others may purchase luncheon tickets: $8 per person

Number of luncheons _____ Friday
_____ Saturday

Number of extra luncheon tickets
_____ x $8 — $_____

GRAND TOTAL ENCLOSED $_____
(includes luncheons & tuition)

Make checks payable to OSMA and mail to OSMA, Department of Administrative and Educational Services, 1500 Lake Shore Drive, Columbus, Ohio 43204-3824. Telephone: (614) 486-2401

COURSES

FRIDAY, NOVEMBER 3

____ **AIDS Update III: 1989 (3 hrs.)**
(9:00 AM to 12:30 PM including break)

____ **Update on Transfusion Medicine (1½ hrs.)**
(2:00 to 3:30 PM)

____ **Current Review of TPA Therapy (1½ hrs.)**
(2:00 to 3:30 PM)

____ **Sleep Disorder Symposium (1½ hrs.)**
(2:00 to 3:30 PM)

____ **Media Training Seminar (3 hrs.)**
(2:00 to 5:30 PM) (No charge — must pre-register — max. reg. 15)

____ **Addiction — The Disease Concept (3 hrs.) Anthropology & Genetics**
(2:00 to 5:30 PM)

____ **Courtroom Appearances: Tips from a Survivor (1½ hrs.)**
(4:00 to 5:30 PM)

____ **Point Counterpoint: Jehovah Witness View of Transfusion (1½ hrs.)**
(4:00 to 5:30 PM)

____ **Office Management of Patient with Obstructive & Chronic Lung Disease (1½ hrs.)**
(4:00 to 5:30 PM)

SATURDAY, NOVEMBER 4

____ **HCFA Presentation (1½ hrs.)**
(9:00 to 10:30 AM)

____ **How to be a Sports Medicine Physician: The Old "Tape and Go" (1½ hrs.)**
(11:00 AM to 12:30 PM)

____ **What's New in Pediatric Cardiology (1½ hrs.)**
(11:00 AM to 12:30 PM)

____ **Treatment of Fungal Infection in Patients with AIDS (1½ hrs.)**
(11:00 AM to 12:30 PM)

____ **Psoriasis (1½ hrs.)**
(11:00 AM to 12:30 PM)

____ **Physicians as Professionals & Parents (1½ hrs.)**
(2:00 to 3:30 PM)

____ **Ethics 101: Application of the AMA's Principles of Medical Ethics (1½ hrs.)**
(2:00 to 3:30 PM)

____ **Orthopedic Sports Medicine for the Primary Care Physician (1½ hrs.)**
(2:00 to 3:30 PM)

____ **MRI and the Primary Care Physician (3 hrs.)**
(2:00 to 5:30 PM)

____ **Infectious Diseases/Antibiotics (3 hrs.)**
(2:00 to 5:30 PM)

____ **Oncology Program (3 hrs.)**
(2:00 to 5:30 PM)

____ **Common Office Emergencies (1½ hrs.)**
(4:00 to 5:30 PM)

____ **Pre-operative Evaluation of the Allergic Asthmatic (1½ hrs.)**
(4:30 to 5:30 PM)

SUNDAY, NOVEMBER 5

____ **Pap Smear Interpretation for the Primary Care Physician (1½ hrs.)**
(9:00 to 10:30 AM)

____ **Office Otolaryngology for the Primary Care Physician (1½ hrs.)**
(9:00 to 10:30 AM)

____ **Active Risk Management (1½ hrs.)**
(9:00 to 10:30 AM)

____ **Office Management of Arthritis (1½ hrs.)**
(9:00 to 10:30 AM)

____ **GI Diagnosis & Therapy: Sharpening Your Skills (3 hrs.)**
(9:00 AM to 12:30 PM)

____ **Office Management & Recognition of Skin Cancer (1½ hrs.)**
(9:00 to 10:30 AM)

____ **Office Ophthalmology for the Primary Care Physician (1½ hrs.)**
(11:00 AM to 12:30 PM)

THE OSMA COMMITTEE ON EDUCATION CERTIFIES
THAT THIS ACTIVITY MEETS THE CRITERIA FOR A MAXIMUM
OF 15 CREDIT HOURS IN CATEGORY I.

The Programs . . .

Oncology Program
Clinical Update on Cancer Management
Date: Saturday, November 4, 1989
Time: 2:00 to 5:30 PM
Program Objectives:

The objective of this multidisciplinary symposium is to provide an opportunity for the primary care physician to gain a good perspective of the current management programs for the common cancers, including breast, lung, colon and ovarian malignancies. A discussion of the use of high dose chemotherapy and bone marrow transplantation will also be included.

Course Director: Robert W. Kellermeyer, MD, Director of Ambulatory Oncology, Ireland Cancer Center, University Hospitals of Cleveland, Cleveland, Ohio

Speakers:

Bernard S. Aron, MD, Director, Division of Radiation Oncology, University of Cincinnati College of Medicine, Cincinnati, Ohio

Hillard M. Lazarus, MD, Director, Bone Marrow Transplantation Program, Ireland Cancer Center, University Hospitals of Cleveland, Cleveland, Ohio

Michael S. Macfee, MD, Director of Gynecologic Oncology, Ireland Cancer Center, University Hospitals of Cleveland

John J. Rinehart, MD, Professor of Medicine, Ohio State University College of Medicine, Columbus, Ohio

Roland T. Skeel, MD, Professor of Medicine, Medical College of Ohio, Toledo

James A. Ungerleider, MD, Medical Oncologist, Dayton, Ohio

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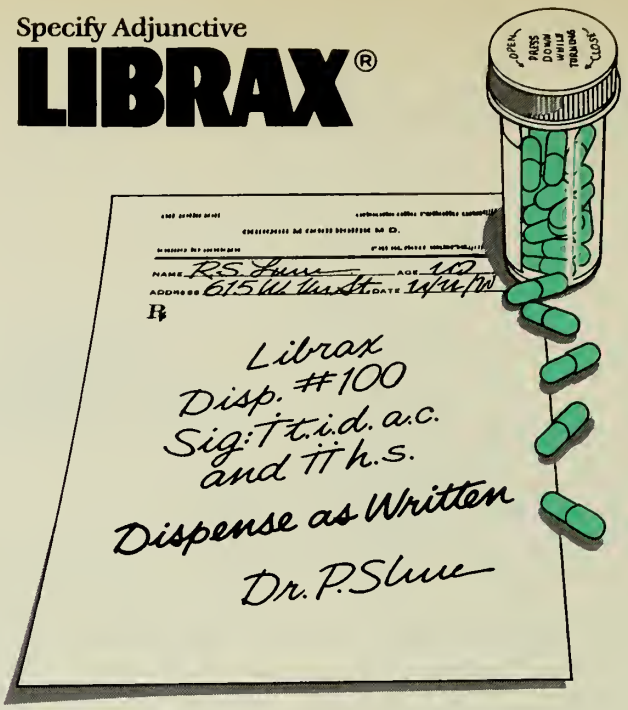

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide.

Please consult complete prescribing information, a summary of which follows:

* Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).
Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.
As with all anticholinergics, inhibition of lactation may occur.
Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).
Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.
Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.
Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

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*Librax has been evaluated as possibly effective as adjunctive therapy in the treatment of peptic ulcer and IBS.

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Please see summary of prescribing information on adjacent page.

1989 Clinical Update Exhibitors

(as of publication deadline)

NAME	BOOTH NO.
American Physicians Life	41
Berwanger Overmyer Associates, Inc.	19
Blue Cross and Blue Shield of Ohio	28
Brentwood Instruments	48
Children's Hospital	64
Dolbey & Company	1
Encyclopaedia Britannica, USA	54
GBS Computers, Inc.	58
Glaxo, Inc.	43
ICL Leasing Inc.	62
Industrial Commission of Ohio	52
A.J. James Cancer Hospital and Research Institute	13
Lederle Laboratories	42
Eli Lilly & Co./Dista Products Co.	47
The Medical Protective Company	66
Michigan X-Ray	63
Miles Inc., Diagnostics Division	59
Ohio Army National Guard	11
Ohio Pork Producers Council	67
Parke-Davis	70
Pfizer Laboratories	18
Physicians Insurance Company of Ohio	60
Physicians Practice Management	46
Roche Laboratories	56
Ross Laboratories	51
Clayton L. Scroggins Associates	55
Syntex Laboratories, Inc.	61
Turner and Shepard, Inc.	69
U.S. Air Force Medical Recruiting	20
The Upjohn Company	53
Wyeth-Ayerst Laboratories	65

EXHIBIT HALL SCHEDULE

Friday, November 3

8:30 AM-6:30 PM
Exhibits Open

Deli luncheon for participants in exhibit hall

5:30 PM-6:30 PM
Reception

(No exhibit set-up on Friday)

Saturday, November 4

8:30 AM-6:30 PM
Exhibits Open

Deli luncheon for participants in exhibit hall

5:30 PM-6:30 PM
Reception

Sunday, November 5

8:30 AM-12:00 Noon
Exhibits Open

12:00 Noon
Exhibits move out
(Must be out by 5:00 PM)

Report of the Annual Business Meeting of the American Medical Association June 22-26, 1989

By Theodore J. Castele, MD
Chairman, Ohio Delegation to the AMA

William J. Marshall, MD
President, Co-Chairman, Ohio Delegation to the AMA

This report covers some of the important issues voted on by the Ohio Delegation at the 1989 Annual Business Meeting of the American Medical Association in Chicago, Illinois, June 22-26, 1989.

There were 92 reports and 265 resolutions considered by the House of Delegates. The following summary contains 14 resolutions submitted by the Ohio Delegation to the AMA, as well as a report on several other items of importance to Ohio physicians.

OHIO RESOLUTIONS

Medicare Terminology (OSMA Sub. Res. 08-89)

The American Medical Association House of Delegates adopted the following resolution in lieu of the resolution submitted by the Ohio Delegation:

"**RESOLVED,** That the American Medical Association/Health Care Financing Administration agreement regarding carrier implementation of Medicare medical necessity reviews be applied before Medicare 'medically unnecessary' notices are mailed; and be it further

RESOLVED, That the AMA continue its efforts to stop 'medically unnecessary' denial notices being sent to patients; and be it further

RESOLVED, That the AMA consider sponsoring and/or supporting legislation to achieve a satisfactory resolution to the problem of 'medically unnecessary' denial notifications."

New PRO Requirement for Pre-Authorization (OSMA Am. Res. 74-89)

The AMA House of Delegates adopted the following resolution in lieu of the resolution submitted by the Ohio Delegation:

"**RESOLVED,** That the AMA seek both medical justification and clarification of the pre-authorization program of the Peer Review Organization (PRO) Third Scope of Work and the criteria for approval; and be it further

RESOLVED, That the AMA seek standards that require competent, licensed and adequately trained medical professionals be employed by the PRO for purposes of pre-authorization review, to require that the PRO define the maximum amount of time necessary for their pre-authorization; and be it further

RESOLVED, That the AMA initiate a program of physician education on the pre-authorization program, standards and methods to obtain approval."

AMA Leadership in Medical Economics Education (OSMA Res. 22-89)

The AMA House of Delegates referred the following Ohio resolution to the AMA Board of Trustees:

"**RESOLVED,** That the American Medical Association work with the Association of American Medical Colleges to (1) publicize the importance of educating physicians and medical students in the area of health-care economics, and (2) promote the establishment of curricula in medical economics at all accredited medical schools; and be it further

RESOLVED, That the AMA develop an informational report or pamphlet summarizing the important issues in the field of health care economics, which describes the relevant AMA publications which are available for purchase, and which will be available to all AMA members upon request; and be it further

RESOLVED, That the AMA establish an externship/fellowship program for those medical students and physicians who seek additional training and experience in the area of health care policy analysis and development."

Herman I. Abromowitz, MD, (left) discusses a point with Joseph Sudimack, MD.

Medicare PRO Point System (OSMA E.R. 03-89)

The AMA House of Delegates adopted the following substitute resolution in lieu of three resolutions, including one from Ohio, on the subject of the Medicare PRO Point System:

"**RESOLVED,** That the AMA direct efforts to the Health Care Financing Administration (HCFA) to rescind the Peer Review Organization (PRO) Point System; and be it further

RESOLVED, That the AMA request HCFA to issue a clear policy directive emphasizing to state peer review organizations a more educational Quality Intervention Program as opposed to one of punitive nature; and be it further

RESOLVED, That if rescission is not achieved, the AMA direct its efforts to see that: modifications are made to the point system to minimize its detrimental impact on the practice of medicine and quality of care, including consideration of: (1) addition of additional levels to the existing three levels of severity; and (2) development of a formula that would give consideration to weighing the points assessed against the practitioner in relation to the total volume of cases, especially with regard to minor quality problems; and be it further

RESOLVED, That the AMA pursue with HCFA an addendum to the PRO Third Scope of Work and Quality Intervention Program implementing a fair reconsideration and appeal process that is specialty specific."

Confusion Between Transfer and Patient Dumping (OSMA Am. Res. 28-89)

The AMA House of Delegates changed the name of the resolution to "Confusion Between Inappropriate Patient Transfer and Appropriate Patient Transfer" and adopted the following resolution in lieu of the resolution submitted by the Ohio Delegation:

"**RESOLVED,** That the American Medical Association adopt the position that the use of the term 'patient dumping' for inappropriate patient transfer is offensive and should be discontinued; and be it further

RESOLVED, That the American Medical Association, through existing communications means, attempt to educate physicians, the public, media, various public officials and others regarding the difference between appropriate patient transfers, as defined in existing policy statements, and inappropriate patient transfers."

Uncompensated Care (OSMA Am. Res. 30-89)

The AMA House of Delegates adopted the following Ohio resolution:

"**RESOLVED,** That the American Medical Association widely communicate to the public the problem of uncompensated care and the ever increasing regulations involving such care as well as the detrimental effect that uncompensated care has on the availability of necessary health-care services to many citizens; and be it further

RESOLVED, That the AMA publicize the programs currently instituted to address uncompensated care and pursue additional solutions for dealing with the problem of uncompensated care."

Gatekeeper Control of Treatment (OSMA Am. Res. 05-89)

The AMA House of Delegates amended the resolution submitted by the Ohio Delegation and adopted it as follows:

"**RESOLVED,** That the AMA support new federal regulations to limit health maintenance organizations (HMOs) from using a financial incentive system that induces gatekeepers to limit patient access to care; and be it further

RESOLVED, That the AMA keep physicians informed of any such regulations."

President-Elect John A. Devany follows a resolution.

Resource-Based Relative Value Scale Geographic Differentials (OSMA Am. Res. 40-89)*

The AMA House of Delegates adopted the following substitute resolution in lieu of two resolutions, including one from Ohio, on the subject of RBRVS geographic differentials:

"**RESOLVED,** That the American Medical Association reaffirm its policy that geographic variations under a Medicare payment schedule reflect only valid and demonstrable differences, especially medical liability premiums, in physician practice costs, with further adjustments as needed to remedy demonstrable access problems in specific geographic areas."

*For further information regarding AMA House of Delegates policy on the issue of Resource-Based Relative Value Scales, please see page 798.

Nursing Home Rules (OSMA Am. Res. 41-89)

The AMA House of Delegates adopted the following substitute resolution in lieu of the one submitted by the Ohio Delegation:

"**RESOLVED,** That the AMA urge the Department of Health and Human Services to seek consultation and advice from the AMA in developing rules and regulations that affect medical care in the nursing home setting; and be it further

RESOLVED, That the AMA work with appropriate groups for the purpose of developing mutually supported positions regarding medical care regulations in nursing homes; and be it further

RESOLVED, That the AMA continue to monitor federal and state legislation and regulations which affect physicians involved in nursing home care and to provide testimony and information about appropriate medical management of nursing home patients to regulatory and/or licensing bodies."

News Media Access to New Scientific Developments (OSMA Am. E.R. 02-89)

The AMA House of Delegates adopted the following substitute resolution in lieu of the one submitted by the Ohio Delegation:

"**RESOLVED,** That the American Medical Association request that the National Institutes of Health (NIH) and the Food and Drug Administration (FDA) mandate that all information developed in any clinical trials, or by adverse drug or device reaction reports, be first released to the medical and scientific communities prior to being released to the public."

Claire Wolfe, MD, meets the press.

Prohibit Smoking and Use of Tobacco Products (OSMA Sub. Res. 51-89)

The AMA House of Delegates adopted the following substitute resolution in lieu of two resolutions, including one from Ohio, on the subject of smoking and use of tobacco products:

"**RESOLVED,** That the American Medical Association reaffirm its established policy regarding a smoke-free society with the addition of the following:

1. Advocate that all American hospitals ban tobacco use by January 1, 1991;
2. Urge physicians to prohibit

smoking and use of tobacco products in their offices; and
3. Work toward legislation and policies to promote a ban on smoking and use of tobacco products in hospitals, health-care institutions and educational institutions (including medical schools)."

Waiting Period Before Gun Purchase (OSMA Res. 54-89)

The AMA House of Delegates adopted the following Ohio resolution:

"**RESOLVED,** That the American Medical Association support legislation calling for a waiting period of at least one week before purchasing any form of firearm in the United States."

Mandatory Random Drug Testing in Competitive Sports (OSMA Res. 63-89)

The AMA House of Delegates referred the following Ohio resolution to the AMA Board of Trustees for further consideration:

"**RESOLVED,** That the American Medical Association recommend to the High School Athletic Associations throughout the country that a mandatory random drug testing program be established as a requirement for participation in scholastic sports; and be it further

RESOLVED, That the AMA recommend that a similar program be established by the National Collegiate Athletic Association and professional leagues as a requirement for participation in collegiate and professional sports."

Warning Label on Personal Listening Devices (OSMA Sub. Res. 66-89)

The AMA House of Delegates adopted the following resolution in lieu of one submitted by the Ohio Delegation:

"**RESOLVED,** That the AMA study the problem of the personal dangers of devices that may induce hearing loss, including listening devices with earphone speakers; and be it further

RESOLVED, That a report be prepared that includes recommendations for mechanisms to prevent hearing loss caused by misuse of personal listening devices."

Anti-smoking proponents (l. to r.): Theodore J. Castele, MD, Seymour F. Ochsner, MD, of New Orleans, and former U.S. Surgeon General C. Everett Koop.

RESOLUTIONS AND REPORTS ORIGINATING FROM NON-OHIO SOURCES

Resource-Based Relative Value Scale for Physician Services

The AMA House of Delegates adopted an amended Board of Trustees report that provides an update on recent events involving the RBRVS and makes the following recommendations:

1. That the AMA reaffirm its support for development and implementation of a Medicare indemnity payment schedule according to the policies established in Board of Trustees Report AA (I-88);
2. That the Association support reasonable attempts to remedy geographic Medicare physician payment inequities that do not substantially interfere with the AMA's general support for an RBRVS-based indemnity payment system;
3. That the Association continue to work to ensure that implementation of an RBRVS-based Medicare payment schedule occurs upon the expansion, correction and refinement of the Harvard RBRVS study and data as called for in Board Report AA (I-88), and upon AMA review and approval of the relevant proposed enabling legislation; and
4. That the Association oppose any effort to link the acceptance of an RBRVS with any proposal that is counter to AMA policy, such as expenditure targets or mandatory assignment;
5. That the AMA continue to oppose the arbitrary and unwarranted use of so called "overpriced procedure" reductions as part of the fiscal year 1990 budgetary process, the use of data generated by the yet-to-be-completed Harvard RBRVS study to determine such payment cuts, and especially, the use for this purpose of

RBRVS data for specialties whose RBRVS results are being restudied as part of Phase II of the RBRVS study;

6. That in the event that Congress decides to act on physician payment reform in the interval between meetings of the House of Delegates, the House believes that the Board of Trustees will exercise its responsibilities to act with prudence and leadership in seeking the best possible result for medicine consistent with the principles contained in Board of Trustees Report AA (I-88); and
7. If the federal government chooses to reduce reimbursement for certain "targeted procedures," the AMA lobby strongly to limit such reductions to geographic areas where current reimbursement exceeds the mean national reimbursement for that procedure.

In addition, the AMA House of Delegates adopted the following amended resolution:

"**RESOLVED,** That the AMA develop and aggressively seek congressional sponsorship and support for federal legislation that would allow the AMA and state medical associations, on behalf of physicians, to negotiate payment schedules on federal and state policies, respectively, impacting on physician reimbursement."

Expenditure Targets Under Medicare

The AMA House of Delegates adopted two resolutions that state that AMA is strongly opposed to the introduction of expenditure targets, as well as a Board of Trustees report that details the AMA's rationale and efforts to prevent the imposition of Medicare expenditure targets.

Expenditure targets are government-set expenditure goals for total physician services under

Hart Page receives AMA Distinguished Service Award

What do Jerry Lewis, Betty Ford and OSMA veteran Hart Page have in common? Each received a "Citation of a Layman for Distinguished Service Award" on June 18 at the 1989 AMA House of Delegates Meeting in Chicago.

At its 1989 Annual Meeting, the OSMA House of Delegates approved a "resolution of congratulations" to Hart Page, CAE, for being chosen to receive the prestigious award.

The AMA Citation of a Layman award is given to individuals who are not of the medical profession, but who have helped to achieve the ideals of medicine by cooperation or aid in the advancement of medical science, medical education or medical care.

As executive director of the OSMA for 40 years, Hart Page was instrumental in developing programs and services to help Ohio physicians provide the highest quality care for their patients.

As the 1989 AMA Awards booklet observed, Hart Page's "dedication to the medical profession and his concern for his fellow man is a tribute to all medical executives."

Hart Page addresses the AMA House of Delegates after receiving the award.

Hart Page's family joined him at the 1989 AMA Annual Meeting in Chicago.

Medicare Part B. If the targets are exceeded, Medicare physician payment updates to reflect increases in practice costs and changes in patient access will be adjusted downward accordingly across the board. The purpose of expenditure targets is to reduce the amount of physician services the government pays for. They are designed and justified, by the PPRC and others, on the need to reduce the federal deficit.

The concept of targets is wrong in principle. They will be unworkable and unfair in practice. The targets are said to take into account increased demand and other factors that would increase costs. But it is fatally naive to assume the targets will do that.

Expenditure targets will erode Medicare benefits through diminished access to care and will lead to arbitrary and unwarranted societal rationing of needed medical services, as has begun to occur in those Canadian provinces whose policies reflect such limits. Expenditure targets constitute a radical departure from our nation's commitment, in establishing the Medicare program, to provide the elderly with all necessary medical care. Moreover, the enforcement of such targets through reductions in conversion factor updates will erode the resource cost basis of the new payment system. In contrast to the use of expenditure targets, the Association continues to believe that the appropriate manner in which to deal with recent increases in the volume and intensity of medical services is to develop and disseminate practice parameters for high-cost/high-volume services and to refine and efficiently administer clinically based utilization and quality review.

J. James Anderson, MD, and S. Baird Pfahl, MD, study the resolutions.

The *government* — not the medical profession — will establish the targets. The government's stated first concern for Medicare is to reduce spending to reduce the deficit. And as you all know, the government's record in setting fair reimbursement levels is uniformly bad.

Even if the government were committed to fair targets and had a fair process for physician negotiation and input (of which there is none proposed), targets cannot be established scientifically, either before or after the services are provided. There simply is no way to measure or prove appropriate increases in demand or appropriate increases in costs from technological advances. The targets will inevitably be arbitrarily low as health-care spending competes with other government priorities. That is the experience in Canada and every other country that has capped or targeted government health-care expenditures.

After lengthy discussion, the AMA House of Delegates adopted the following substitute resolution on the issue:

"**RESOLVED,** That the American Medical Association reaffirm its willingness to participate in efforts to control the cost of Medicare in a manner that preserves the quality and availability of health care to Medicare recipients; and be it further

Edmund C. Casey, MD.

RESOLVED, That the AMA reaffirm its position that the Medicare program establish actuarially sound financing of benefits as stated in Board of Trustees Report MM (A-86); and be it further

RESOLVED, That the AMA urge Congress to incorporate the following considerations when applying budgetary controls to Medicare in place of expenditure targets:

a. Assure a high priority to health care for Medicare patients in relation to other programs when allocating federal funds.
b. Given Medicare's finite resources, develop a mechanism to channel those resources to those patients with greater financial need and to require a proportionately larger financial contribution by the more affluent toward their own health care.
c. Reduce the cost of defensive medicine (approximately $20 billion a year) caused by the present tort system."

RCT Proposal Implementation: Status Report

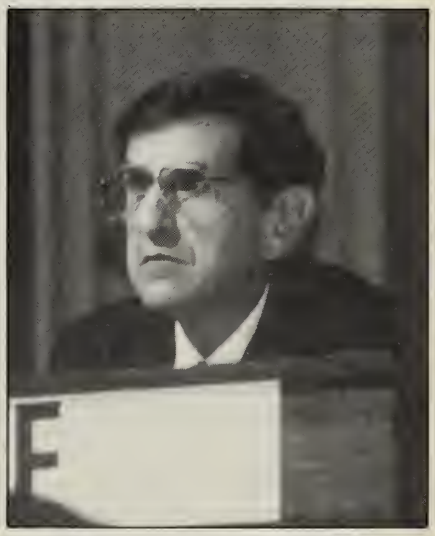
The AMA House of Delegates adopted a Board of Trustees report that summarized the activities that have taken place in the last six months to implement the Registered Care Technician proposal, including meetings of a National Advisory Committee and its two subcommittees, one to review existing programs similar to the RCT concept, and one to study the safety and cost effectiveness of RCTs as members of the health-care team. Four existing programs have been reviewed to date. The selection of demonstration sites for the RCT test programs is not yet completed, but a symposium for program coordinators for the RCT program is scheduled for August, 1989. Meetings with nursing organizations continue to be held.

President William J. Marshall, MD, and Owen E. Johnson, MD.

Drug Abuse in the U.S.: Strategies for Prevention

The AMA House of Delegates adopted an amended Board of Trustees report that recommends that the AMA:

1. Urge the Alcohol, Drug Abuse and Mental Health Administration to support research into special risks and vulnerabilities, behavioral and biochemical assessments and intervention methodologies most useful in identifying persons at special risk and the behavioral and biochemical strategies that are most effective in ameliorating risk factors.
2. Urge the federal office for Substance Abuse Prevention to continue to support community-based prevention strategies that include:
   a. Special attention to children and adolescents, particularly in schools, beginning at the pre-kindergarten level.
   b. Changes in the social climate (i.e., attitudes of community leaders and the public), to reflect support of drug and alcohol abuse prevention and treatment, eliminating past imbalances in allocation of resources to supply and demand reduction.
   c. Development of innovative programs that train and involve parents, educators, physicians and other community leaders in state-of-the-art prevention approaches and skills.
3. Send letters to major media programming and advertising agencies to encourage the development of more accurate and prevention-oriented messages about the effects of drug and alcohol abuse.
4. Pursue the development of advanced educational programs to produce qualified prevention specialists, particularly those who relate well to the needs of economically disadvantaged, ethnic, racial and other special populations.
5. Investigate the feasibility of developing a knowledge base of comprehensive, timely and accurate concepts and information as the "core curriculum" in support of prevention activities.



Stanley J. Lucas, MD.

6. Urge federal, state and local government agencies and private sector organizations to accelerate their collaborative efforts to develop a national consensus on prevention and eradication of alcohol and drug abuse. Toward this end, the AMA and other national organizations are cosponsors of a 1990 National Assembly on Addictive Disorders: Enlisting Scientific Knowledge in the War on Drugs.

AIDS

The AMA House of Delegates adopted an amended Board of Trustees report which includes the following guidelines for hospital-based, HIV-infected health-care workers:

1. A health-care worker who performs invasive procedures and has reasonable cause to

believe he/she is infected with HIV should determine his/her sero status or act as if that sero status is positive.

2. If an infected health-care worker performs invasive medical procedures as a part of his/her duties, then the health-care worker should request that an ad hoc committee be constituted to consider which activities the infected health-care worker can continue to engage in without risk of infection to patients. Membership of this committee may be composed of, but not necessarily limited to, an infectious disease specialist familiar with HIV transmission risks, the pertinent hospital department chairperson, a hospital administrator, the infected health-care worker's personal physician and the infected health-care worker.
3. A confidential review system should also be established by the ad hoc committee to monitor the health-care worker's fitness to engage in invasive health-care activities. Any restrictions or modifications to health-care activities for patient safety should be determined by the ad hoc committee based on current medical and scientific information.
4. Knowledge of the health-care worker's HIV status should be restricted to those few professionals who have a need to know. Except for those with a need to know, all information on the sero status of the health-care worker should be held in the strictest confidence.
5. As general rule or until there is scientific information to the contrary, the health-care worker should be permitted to provide health-care services as long as there is no identifiable risk of patient infection and no compromise in physical or mental ability of the health-care worker to perform the health-care procedures.
6. Where restrictions, limitations, modifications or a change in health-care activities are recommended, the ad hoc committee should do its utmost to assist the health-care worker to obtain financial and social support for these changes.
7. If intra-institutional confidentiality cannot be assured, health-care facilities should make arrangements with other organizations such as local or state medical societies to serve the functions of the ad hoc committee.

In addition, the AMA House of Delegates referred 10 resolutions focusing on a wide range of AIDS-related issues to the Board of Trustees for a report back at the 1989 AMA Interim Meeting. Two years ago, the AMA adopted its landmark AIDS policy, Board of Trustees Report YY (A-87), which provided physicians with a coherent, comprehensive response to the AIDS epidemic. The House of Delegates noted that the issues involving confidential testing for HIV, adoption of voluntary hospital testing policies, the categorization of HIV as a sexually transmitted disease, and mandatory reporting of test results to public health officials with contact tracing have increased in complexity since the original policy was developed and that advances in the detection of viral infection have increased the estimates for viral latency while improved therapies are available for HIV and opportunistic infections. Therefore, it is felt that an updated AMA policy report on AIDS is needed to assist physicians in providing their patients with the most appropriate medical care and to assist the medical community in halting the spread of the virus.

Study of the Canadian Health-Care System

The AMA House of Delegates adopted an amended Board of Trustees report that evaluated the Canadian health-care system and contains the following summary assessment:

"In theory, Canadians have an ideal health-care system: a comprehensive system of primary care, removal of all financial barriers to access to primary care, decentralization of health programs and professional standards of care equal to or better than those of most Western countries. But in many important ways Canada's system is lacking:

- It is less responsive to consumers than the U.S. system.
- Much of its capital structure is neglected.
- Adoption of major medical technologies lags far behind the U.S.
- There are growing backlogs for a variety of surgical and emergency procedures.
- It does not reward or encourage high performance by providers.
- It is rigid and inflexible.

The Canadian system appears to be poorly suited to postindustrial societies with changing human service needs, and will grow more and more to resemble the British National Health Service with its severely depreciated capital base and explicit rationing of medical care.

The type of complete government-provided health insurance found in Canada leads inexorably to the imposition of government controls over the size and character of the health-care system. While costs may be reduced in this manner, the centralized controls required make it an unsatisfactory model to be followed in the U.S."

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a wide range of subjects that are of interest to physicians. These reports, prepared by the AMA Board of Trustees, councils, committees and staff, contain a wealth of information.

A listing, by title, of some of the reports follows. If you would like a copy of these reports, please contact the OSMA office.

1. Health Warning Labels on Beverage Alcohol Containers
2. Development of Practice Parameters
3. Opposition to Nationalized Health Care
4. Living Wills, Durable Powers of Attorney and Durable Powers of Attorney for Health Care
5. Curtailing Prescription Drug Abuse While Preserving Therapeutic Use — Recommendations for Drug Control Policy
6. Tobacco-Free Society by the Year 2000: Supplemental 1989 Progress Report
7. Guidelines for the Use of Restraints in Long-Term Care Facilities
8. Impact of U.S. Tobacco Exports on the Worldwide Smoking Epidemic
9. Global Climate Change: The "Greenhouse Effect"
10. Mammographic Criteria for Surgical Biopsy of Nonpalpable Breast Lesions
11. PRO Sanctioning Procedures

Please send me the following AMA report(s) listed in the Summary of Actions Report of the 1989 AMA Annual Meeting:

Report Number(s): _____

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OBITUARIES

HUGH J. BONNER, MD, Jensen Beach, FL; McGill University Faculty of Medicine, Montreal, Quebec, Canada, 1937; age 79; died July 12, 1989; member OSMA and AMA.

JOHN BUSCHER, MD, Sewickley, PA; Albany Medical College of Union University, Albany, NY, 1969; age 45; died March 28, 1989; member OSMA and AMA.

WILLIAM DONEGAN, MD, Springfield; Loyola University Stritch School of Medicine, Maywood, IL, 1962; age 56; died November 22, 1988; member OSMA.

PETER A. FOMENKO, MD, Zanesville; University of Cincinnati College of Medicine, 1944; age 74; died July 19, 1989; member OSMA and AMA.

CHARLES E. FRALICK, MD, Springfield; Ohio State University College of Medicine, 1942; age 72; died June 18, 1989; member OSMA and AMA.

ROBERT R. HILL, MD, Cincinnati; Eclectic Medical College, Cincinnati, 1929; age 89; died July 13, 1989; member OSMA and AMA.

GEORGE W. JOHNSTON, MD, New Philadelphia; Case Western Reserve University School of Medicine, 1941; age 76; died June 6, 1989; member OSMA and AMA.

MITCHEL NEWMAN, MD, Portsmouth; University of Louisville School of Medicine, Louisville, KY, 1968; age 46; died July 22, 1989; member OSMA and AMA.

LEONARD J. SINGERMAN, MD, Cincinnati; Chicago Medical School, Chicago, IL, 1950; age 64; died July 8, 1989; member OSMA.

CHARLES W. THOMAS, MD, Brookville; Ohio State University College of Medicine, 1931; age 84; died July 10, 1989; member OSMA and AMA.

ISMAIL H. TOLEK, MD, Warren; Tip Fakultesi Andara Universitesi, Ankara, Turkey, 1954; age 65; died July 16, 1989; member OSMA and AMA.

COUNTY COLLECTION

Drug wars and drugstores

Law enforcers in the Akron area want to add some "byte" to their war on drugs by using computers in their review of pharmacy prescription drug records. But members of the Summit County Medical Society (SCMS) have filed a suit to put a muzzle on these so-called "drug sweeps."

The computer system already has been operating for about one year in six Summit County communities — Hudson, Hudson Township, Mogadore, Munroe Falls, Tallmadge and Stow.

Four Akron doctors, a pharmacy owner and two patients filed the civil action lawsuit against these communities, contending that the computer system constitutes illegal search and seizure. The suit was filed in the Summit County Common Pleas Court in June.

Plaintiffs are asking that the court prohibit police in those areas from conducting searches of pharmacy records without warrants. The suit further requests that police stop recording pharmacy information into their computer and that existing information be destroyed.

Proponents of the computer system say that Ohio law permits drug enforcement investigators to review prescription records in order to enforce controlled substance laws. But SCMS attorney Robert F. Linton says that although searches are permissible under Ohio law, they violate U.S. constitutional protections against illegal search and seizure, invasion of privacy and due process of law.

Thus the outcome of the case hinges on a basic constitutional question — what has the highest priority: the fight against the illegal trafficking of drugs or an individual's right to privacy?

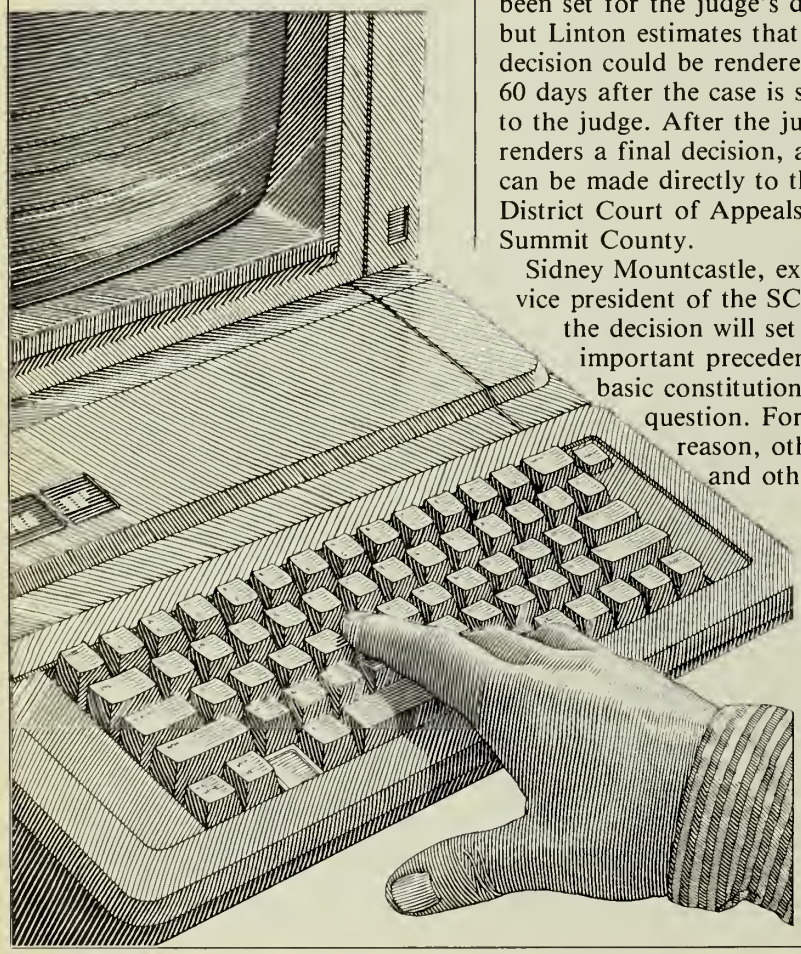
The computer system in question enables police to obtain a patient's name and address, physician's name and the amount of prescribed drug from pharmacy records, and then feed the information into a central police computer. The central computer is currently shared among six Akron area communities and enables

County Collection . . .

Drug wars . . . *continued*

police to cross-check prescription records to see if patients are seeing several physicians or filling prescriptions at a number of different pharmacies.

Police say the program will help to curb prescription drug trafficking, which is estimated to account for 50% to 70% of illegal drug sales. The primary drugs police are tracking include Dilaudid, Percodan, Percoset, Xanax and Ritalin.



Both sides met for a pretrial conference on August 2 to discuss the case with the presiding judge and to determine a schedule for filing legal briefs.

The case is scheduled to be submitted to the judge on September 7. No definite date has been set for the judge's decision, but Linton estimates that a decision could be rendered about 60 days after the case is submitted to the judge. After the judge renders a final decision, appeals can be made directly to the Ninth District Court of Appeals for Summit County.

Sidney Mountcastle, executive vice president of the SCMS, says the decision will set an important precedent for a basic constitutional question. For this reason, other states and other cities in Ohio are keeping close tabs on the case, he says.

The program is already planned or in progress in three other areas in Ohio — Columbus, Youngstown and Fairfield County, according to the *Akron Beacon Journal.* The outcome of the lawsuit could have an influence on how or if the computer system gets on-line in those towns.

In the final analysis, there may be room for compromise in the development of a system that assists police in their drug investigations but also protects patient records. For example, an alternative system operates in New York that uses a code system instead of patient names and requires that police submit a written request in order to inspect pharmacy records.

"There are ways to keep patient information in the hands of physicians and pharmacies," Mountcastle emphasizes. "We hope this (the case) will lead to a more professional and intelligent approach for monitoring illegal drug traffic."

At its May Council meeting, the OSMA Council voted to support the action taken by the Summit County Medical Society. The OSMA has contributed $5,000 to the legal expenses of filing the litigation. The Summit County Medical Society asked its members to give $50 each to a fund to pay for the lawsuit — so far, over $18,000 has been collected. — *Deborah Athy*

Talents Beyond Medicine

Editor's note: The first-time attempt to display the creative talents of members of the Montgomery County Medical Society and its Auxiliary proved to be so impressive we wanted to include it here to give you some idea of the scope of artistry presented that evening. Below, Evan Valassiades, Immediate Past President of the MCMS Auxiliary and chief organizer of the event, describes its success as follows . . .

The quality of the work, both music and art, was amazing. Many people commented later that they knew of people who had not come forth this time, but would probably if the event were held again.

The real key to success was the enthusiasm and pride of the people sharing their talent. Many were shy and not sure if their work would be good enough to be included. These people were encouraged to share on the basis that there would be no judging or selling. We didn't want there to be a factor of competition. These exhibitors and performers were absolutely glowing, slightly nervous, and having a ball. The audience was having a great time because they were enjoying being amazed at their friend's accomplishments.

The "performers were absolutely glowing, slightly nervous, and having a ball."

So many medical meetings are lectures about legislation, insurance and other worrisome subjects. While this education is necessary, we decided to sponsor one program that was simply fellowship — getting to know one another in a comfortable and festive atmosphere. I hope we do this again . . . — *Evan Valassiades, Immediate Past President, Montgomery County Medical Society Auxiliary.*

Robert Finley, MD, presents "Malagania" on the classical guitar.

The violin duet of Jonathon Daitch, MD (left) and Kenneth Christman, MD (far right), is accompanied by Minister of Music Jerry Taylor on piano.

County Collection . . .

Talents beyond medicine . . . *continued*

Keith Callender, MD, reads from his poetry.

Margaret Hayes, MD, makes her debut on the piano.

Jack Weiland, MD, displays a sampling of his wood-carved wildlife works.

Joseph Albrecht, MD, and his wife Peggy provide the show's finale.

Assessing Your Risk Exposure

Self-assessment of risk exposure can help physicians become more aware of their strengths and weaknesses in practice patterns. In an earlier column in this series (January 1989, p. 61), we offered a brief quiz to identify factors that frequently are involved in malpractice lawsuits, based on the claims files of Physicians Insurance Company of Ohio.

The quiz that follows is a continuation of our focus on risk management and loss prevention concerns. There is no firm system to rate your responses, but the greater the total number of "no" answers, the greater the likelihood that a risk exists immediately or in the future.

The Office Setting

We have an efficient system to remind patients of yearly examinations.	Yes ☐	No ☐
An established follow-up system is used when I refer a patient to a consultant.	Yes ☐	No ☐
Patients have an option as to who will treat, if I am practicing with one or more physicians in the same specialty.	Yes ☐	No ☐
I am qualified by training to take calls for all other physicians for who I cover . . . and physicians who cover for me are qualified by training to do so.	Yes ☐	No ☐
My patients are informed as to who is covering.	Yes ☐	No ☐
Office equipment (X-ray, ultrasound, ECG) is checked as required.	Yes ☐	No ☐
X-rays/ultrasound performed in my office are carried out by a qualified person.	Yes ☐	No ☐
I initial and date all incoming diagnostic and medical reports.	Yes ☐	No ☐
Most patients would feel that my office provides pleasant and private examining rooms.	Yes ☐	No ☐
Personal conversations among staff — and telephone conversations at the front desk — cannot be overheard by patients in the waiting room.	Yes ☐	No ☐
Calls on my after-hours answering service are answered by a person (not an electronic device).	Yes ☐	No ☐

Medical Records

If a patient refuses to follow my instructions, I have a procedure to deal with and document the noncompliance.	Yes ☐	No ☐
All contacts with the patient — including by telephone — are recorded in writing.	Yes ☐	No ☐
Written instructions are provided to the patient for specific injuries or illnesses.	Yes ☐	No ☐
Files always document that the patient has been given written instructions.	Yes ☐	No ☐
Signed informed consent forms are obtained by me — not by assistant or nurse.	Yes ☐	No ☐

continued on next page

For all specific office procedures, the patient's signed informed consent form is obtained and placed in the chart. Yes ☐ No ☐

All allergies, bad results and sensitivities are clearly indicated on the patient's chart. Yes ☐ No ☐

Patient Contact

I will accept calls from patients when requested to do so by my staff. Yes ☐ No ☐

In screening calls, the staff is careful not to build a barrier between my patient and me. Yes ☐ No ☐

I have instructed my staff not to renew prescriptions without my signature. Yes ☐ No ☐

The preceding items can be used as part of a continuing assessment of office practices and can assist physicians and their staffs in lessening the probability of risk. In addition, greater focus on these practice patterns offer further protection for both doctor and patient in the office setting.
OSMA

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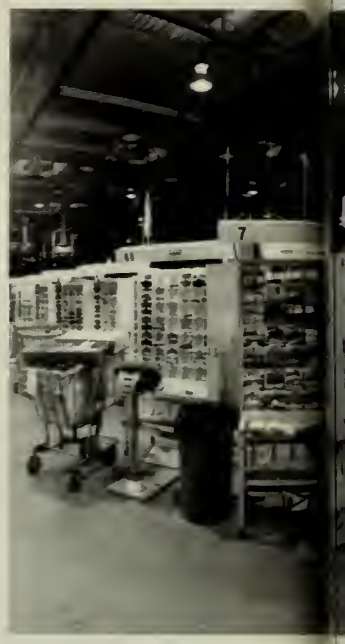

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County Medical Society Executives Meet

County medical society executives and other medical executives met in Huron, Ohio on July 25-26, 1989.

Ray Bumgarner, Executive Director of the Medical Board, Thomas Gretter, MD, Medical Board member, and Douglas Graff, OSMA staff attorney, discuss Medical Board issues.

John Kasper of the AMA Department of Foreign Medical Graduates.

Elayne Biddlestone, Director of Peer Review, Academy of Medicine of Cleveland.

John A. Devany, MD, William J. Marshall, MD, and Barbara Marshall, OSMA-A President, lend an ear to county executive speakers.

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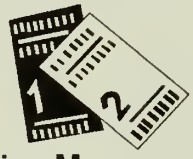

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As a member, you are kept informed through research, analysis and reporting of up-to-date information on health care concerns through OSMA's professional publications. Marketing tools and free patient education materials are also available.

As a member, you are invited to take advantage of the other benefits offered by the OSMA and to call us if you have a special need.

OSMA is at your service when you are a member. Your attention is called to the deadline of December 31, 1989. That is when your membership will expire if your 1990 dues have not been paid.

For further information about your membership, contact Katherine E. Wisse, Director, Department of Membership Development.

For further information about the benefits and who to contact, consult the blue "OSMA Working for You" services and activities pamphlet sent to you earlier this year.

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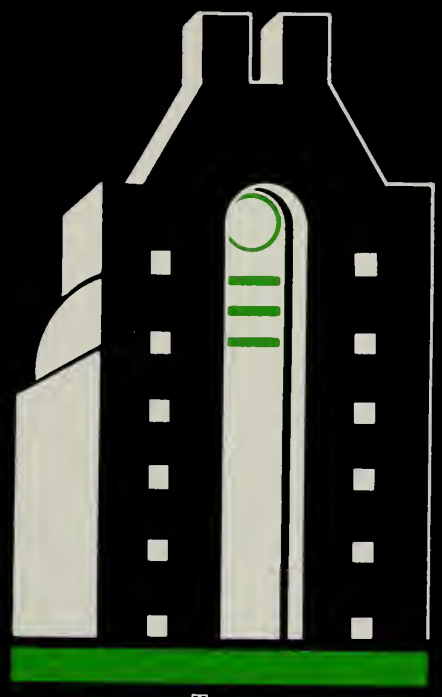

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AMBULATORY CASSETTE EEG IN EPILEPSY EVALUATION

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The economy and effectiveness of 24-hour ambulatory cassette EEG (AEEG) are increasingly recognized. We reviewed 735 AEEGs recorded between 1983 and 1989. These findings suggest that AEEG may confirm the ictal original of attacks in patients with known epilepsy, and may improve the yield of abnormality in epileptics with normal interictal EEG. Focal slowing may be seen less well on AEEG, and the yield of AEEG is low in random sampling of patients with infrequent or nonspecific symptoms.

Introduction

The EEG remains the laboratory test of choice in the diagnosis and categorization of epilepsy.[1] Although the diagnostic specificity of epileptiform EEG discharges such as spikes, sharp waves and spike-wave discharges is well established, the routine clinical EEG of 20 to 60 minutes duration is normal in 25% to 60% of epilepsy patients.[2] Serial EEG recordings improve the yield of abnormality, but approximately 10% of patients have persistently normal interictal EEGs.[3] Since the introduction of cassette recording devices by Holter in 1961,[4] their utility in ECG and ECG monitoring has been amply demonstrated.[5] A high yield of abnormality has been shown in generalized seizure disorders,[6] while the yield is slightly less but still substantial in the partial epilepsies.[7] A considerable improvement in diagnostic yield has been shown in neonatal[8] and childhood[9] seizure disorders, and initial application to seizure monitoring in the emergency room and intensive care unit has been promising.[10] In contrast, abnormality is infrequent in psychiatric disorders,[11] although abnormalities have been reported in some mood disorders with paroxysmal features which respond to antiepileptic drugs.[12] Recent studies [13,14,15] indicate a substantial increase in yield of abnormality as compared to the routine EEG, but more limited application with random sampling, nonspecific symptoms or infrequent paroxysms. We have studied the clinical utility of ambulatory cassette EEG in the evaluation of patients referred to an academic medical center for suspected epilepsy or refractory seizures.

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Subjects and Methods

We retrospectively reviewed clinical and EEG records of 735 patients who had interictal EEGs and 24-hour ambulatory EEGs (AEEGs) between 1983 and 1989. EEGs were recorded in the partially or completely sleep deprived state, and were of 60 minutes duration. Grass tin cup electrodes (Grass Instrument Company, Quincy, Massachusetts) were affixed with collodion at International 10-20 electrode placements. Seventeen-channel EEGs were recorded on Nihon Kohden electroencephalographs (Nihon Kohden America, Irvine, California) with hyperventilation and intermittent photic stimulation, utilizing anteroposterior and transverse bipolar and referential montages. Twenty-four-hour AEEGs were recorded with Oxford Medilog 4-24 systems, and recordings were interpreted with visual and auditory display on a PMD 12 unit (Oxford Medical, Inc., Clearwater, Florida). The following electrode derivations were utilized: T5-F7, F5-F6, F8-T6 and ECG. Patients were instructed in the use of an event marker to indicate seizures or other symptoms and in maintenance of a diary.

Results

Comparison of 24-hour AEEGs and sleep-deprived EEGs is summarized in Table 1. Two hundred fifty-five AEEGs and interictal EEGs were abnormal (34.7%). Seizures were recorded in 150 AEEGS, but only six EEGs. Of the 150 seizures 103 were attended by epileptiform activity, while the others had no cerebral correlates but were indicated by patient diary to involve loss of consciousness, falling or bilateral motor manifestations. Eighty-five interictal EEGs had slowing or epileptiform activity while AEEGs were normal (11.6%); the interictal EEG abnormality missed on AEEG was focal frontal or temporal slowing in 76 of 85 patients, and the abnormalities had no clinical correlates. One hundred thirty-five AEEGs showed slowing or epileptiform activity while EEG had previously been normal (18.4%). Ninety-nine of 135 AEEGs showed unilateral or bilaterally synchronous epileptiform activity without clinical correlate, while clinical seizures accompanied by EEG abnormality were recorded in 36. AEEG and EEG were normal in 260 cases (35%), and 18 patients had clinical attacks without cerebral correlates on AEEG, all of them involving dizziness, drowsiness, anxiety or headache.

The relationship between EEG and AEEG findings and presence or absence of evidence of epilepsy by history, seizure observation or abnormal neurologic examination is shown in Table 2. Forty of 135 patients with normal EEG and abnormal

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Table 1
Relationship between AEEG and EEG in epilepsy evaluation

ABNORMAL AEEG/ ABNORMAL EEG	255 (34.7%)
Seizures recorded	150
Epileptic seizure documented	103
NORMAL AEEG/ ABNORMAL EEG	85 (11.6%)
Focal slowing	76
Epileptiform activity	9
ABNORMAL AEEG NORMAL EEG	135 (18.4%)
Epileptiform activity	99
Seizures recorded	36
NORMAL AEEG/ NORMAL EEG	200 (35%)
Clinical seizures without cerebral correlate	18
Epileptic seizure documented	0

Table 2
EEG, AEEG and Clinical Evidence of Epilepsy

	Abnormal AEEG/ Abnormal EEG	Normal AEEG/ Abnormal EEG	Abnormal AEEG/ Normal EEG	Normal AEEG/ Normal EEG
History consistent with seizures	200	60	40	30
History of cerebral event predisposing to seizures	167	21	32	25
Witnessed attack consistent with seizure	118	39	51	5
Abnormal neurologic examination	107	36	40	28

AEEG had objective evidence of epilepsy. Of 260 individuals with both AEEG and EEG normal, 230 had no clinical evidence of epilepsy and normal neurologic examinations. Of 85 patients with abnormal EEGs but normal AEEGs 60 had clinical evidence in support of epilepsy, while 200 of 255 had seizures reasonably documented by history, witnessed seizures or abnormalities of neurologic examination.

Table 3 summarizes the relationship between EEG and AEEG results and frequency of attacks suspected of being seizures. All 57 patients with daily or every other day attacks had abnormalities in both AEEG and EEG. All patients who had these studies because of a single episode suspected of ictal origin had normal EEG and AEEG. Almost all patients with episodes that occurred less often than every two weeks had normal EEG and AEEG (150 of 169), and none had abnormalities on both studies. AEEGs and EEGs were most often both abnormal (148 of 257) when attacks occurred once or twice per week, but 34 of 257 individuals had normal EEG and AEEG despite one or two attacks per week. Of the 135 AEEGs that showed abnormality when the interictal EEG was normal, 42 were in the group that had one to two attacks per week, while 80 were in the group with weekly or biweekly attacks.

Discussion

More than half of AEEGs obtained for evaluation of documented or suspected epilepsy showed epileptiform activity or captured seizures. Sleep-deprived interictal EEG was abnormal in approximately 45%. The increase in incidence of abnormality overall was only approximately 7%, less than that documented in some series,[15] but the additional clinical information was often crucial, as it occurred principally in patients with normal interictal EEG or took the form of epileptic or nonepileptic seizures captured on AEEG which were not recorded on the interictal EEG. The AEEG thus provided evidence in support of epilepsy in some patients with normal interictal EEGs, and confirmed or disproved the epileptic nature of clinical attacks in patients with previously diagnosed epilepsy.

In a few cases the interictal EEG was abnormal, generally showing focal slow activity, but this was not seen in the 24-hour cassette EEG. Most of these patients had infrequent attacks, and none had evidence in support of epilepsy from history, previous observation of seizures or neurologic examination. In general, patients with single episodes, clinical attacks of nonspecific character, and little or no clinical evidence for epilepsy otherwise had normal EEG and AEEG, and all of those who had a single episode of possibly epileptic origin had both studies normal.

Early studies of cassette EEG demonstrated a high yield of abnormality in generalized epilepsies, particularly those attended by spikewave discharges.[6] In adults with partial epilepsy, up to 90% of epileptiform abnormalities were recorded on AEEG as compared to inpatient cable telemetry, and 24-hour ambulatory EEG recordings provided as much positive or negative information as intensive inpatient monitoring in 60% of diagnostic admissions.[7]

Cassette EEG recording documented subclinical seizure activity in high-risk neonates and its absence in low-risk infants, and the number of seizures and duration of epileptiform activity were related to perinatal outcome.[8] Ambulatory EEG monitoring has also been shown to have a diagnostic yield equivalent to prolonged video-EEG monitoring in children, who often tolerate inpatient EEG monitoring poorly.[9]

The overall yield of seizures during epilepsy evaluation with AEEG has ranged from 16% in unselected patients to 77% with daily seizures. In unselected patients, 10% to 15% of recordings have yielded positive evidence in support of epilepsy,[12] while the proportion of attacks identifiable as seizures has ranged from 23 to 73%.[13,14]

The largest recent series has shown a high incidence of AEEG abnormality with clinical attacks involving involuntary motor activity or episodic unconsciousness, approximately 25%, but yields as low as 2% in dizziness or anxiety. This accords with our observation that the incidence of abnormality was high in patients with previous suggestive evidence for epilepsy by history of examination and low in neurologically intact patients with nonspecific symptoms. Comparison of AEEG and preceding laboratory EEG has demonstrated a tenfold increase in AEEG

Table 3
EEG, AEEG and Frequency of Clinical Attacks

	Abnormal AEEG/ Abnormal EEG	Normal AEEG/ Abnormal EEG	Abnormal AEEG/ Normal EEG	Normal AEEG/ Normal EEG	Total
Frequency of Attacks					
Daily or every other day	57	0	0	0	57
Every 3-7 days	148	33	42	34	257
Every 7-14 days	50	46	80	26	202
Less than every 14 days	0	6	13	150	169
Single episode	0	0	0	50	50

yield over laboratory EEG recording, with ⅓ of recorded absence seizures occurring in patients who had no spike wave discharges during routine EEG and 56% of focal epileptiform abnormalities in partial seizure patients who had no routine EEG abnormality.[15] Our increase in yield was somewhat lower, probably because of the use of sleep-deprived EEGs of 60 minutes duration as initial evaluation rather than a shorter routine EEG with fewer activating procedures.

A 24-hour cassette EEG recording generally costs $400 to $500, with a range of interpretation fees from $50 to $200 nationally; based on average costs of hour-long standard EEGs, an inpatient EEG of comparable length would cost $2,000 to $3,000, with a corresponding interpretation fee plus the expense of inpatient stay.

24-hour AEEG is clearly useful and economical in epilepsy evaluation. Our findings indicate that the yield is low in intermittent sampling of patients with infrequent or nonspecific symptoms, and that focal slow abnormality may be better seen on routine EEG than on AEEG. AEEG may confirm the ictal origin of attacks in patients with known epilepsy, and may improve the yield of abnormality in epileptics with normal interictal EEG. It thus provides an adequate intermediary assessment of epilepsy between routine outpatient EEG and intensive inpatient EEG monitoring.

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Caput Medusae

By A.E. Rodin, MD, of the OSMA Art and Culture Committee

Portal hypertension can result in distention of superficial periumbilical veins of the skin, due to back pressure of blood from the portal vein which is compressed by cirrhotic liver tissue.[1] The wavy appearance of these distended veins in the skin has been compared to the hair of Medusa. She was one of the three Gorgons of Greek mythology, monstrous females with huge teeth, brazen claws and snakes for her hair.[2]

Medusa was once beautiful, but was deprived of her charms by Minerva (Athena) because she had defiled an Athenian temple by sleeping there with Poseidon (Neptune). Her beautiful ringlets were changed into hissing snakes, and all who looked upon her turned into stone. Her head was cut off by Perseus who approached her when she was asleep, and only looked at her image reflected in his shield.[3] He gave the head to Minerva and it still retained its power.

The eponym Caput Medusae refers to Medusa's physical appearance rather than her other attributes. Sigmund Freud suggested that the terror of observing her head was symbolic of the terror of castration, and that her snakes were symbolic of pubic hair.[4] In a different type of literature, but still with psychological overtones, Medusa is variously depicted in comic books as a variety of characters, some evil and some good.[5] All have "snakey" hair. Such an appearance is the reason the name Medusa was given to jellyfish by Carl Linnæus (Linné).[6]

A nonliterary umbilical eponym is the Sister Mary Joseph node, named after a surgical assistant at the turn of the century who noted an umbilical nodule while preparing a patient for surgery at the Mayo Clinic.[7] It is caused by invasion of the umbilicus by an intra-abdominal malignancy, and may be its first sign.

1. Monckeberg, J.G.: *Ribbert's Lehrbuch der Allgemeinen Pathologie und der Pathologischen Anatomie:* 8th ed., Leipzig, F.C.W. Vogel, 1921, p. 148.
2. Bulfinch, T.: *The Age of Fables or Beauties of Mythology:* revised ed., J.L. Scott Ed., Philadelphia, David McKay, 1898, pp. 141-144.
3. Gayley, C.M.: *The Classic Myths in English Literature and Art:* new ed., Boston, Ginn & Co., 1939, p. 209-210.
4. Freud, S.: *Medusa's Head [1922]: in Sexuality and the Psychology of Love,* P. Rieff Ed., N.Y., Collier Books, 1970, pp. 212-213.
5. Adams, K.A.: "Octopoid" Genitality and the Medusal Madonna: *J. Psychohistory,* 10:409-462, 1983.
6. Skinner, H.A.: *Origin of Medical Terms:* Baltimore, Williams & Wilkins, 1961, p. 269.
7. Key, J.D. et al: Sister Mary Joseph's Nodule and its Relationship to Diagnosis of Carcinoma of the Umbilicus: *Minnesota Med,* 59:561-566, 1976.

Fig. A: Head of Medusa with snake's hair.[2 p.141]
From: Rodin, A.E. & Key, J.D.: *Medicine, Literature and Eponyms. An Encyclopedia of Eponyms Derived from Literary Characters:* Malabar, FL, Robert E. Krieger, 1989.
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"5. Osler W: Modern Medicine, ed 3, Philadelphia, Lea & Febiger, 1927, vol 5, p 66."

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OHIO, NORTHEAST/CLEVELAND: Emergency department physicians needed for 40,000+ patient volume hospital emergency department in Greater Cleveland area. Physician must be Board-certified in emergency medicine, residency-trained in emergency medicine, or be Board-prepared in emergency medicine. Salary and benefits package worth $130K. Included is liability, disability and life insurance, retirement program, vacation, continuing education and comprehensive health coverage. Full partnership eligibility in two years. Interested individuals, please submit CV to: P.O. Box 2600, Lakewood, OH 44107.

OHIO: Part-time ER work — $30-45 per hour. Recent ACLS certification required, ATLS, primary care experience a plus. Excellent medical staff back-up for major medical/surgical cases. ERs vary from quiet to moderate. Contact: Emergency Consultants, Inc., 2240 S. Airport Road, Room 26, Traverse City, MI 49684, (800) 253-1795 or in Michigan (800) 632-3496.

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OSMA Notebook

Register for the OSMA Clinical Update Meeting . . . Have you made plans to attend the 1989 OSMA Clinical Update Meeting? If not, you'll miss out on more than 25 clinical programs and 70 exhibits. The meeting will be held November 3-5 at the Stouffer Center Plaza in Dayton. For registration information, turn to page 788 in this month's issue of *OHIO Medicine.*

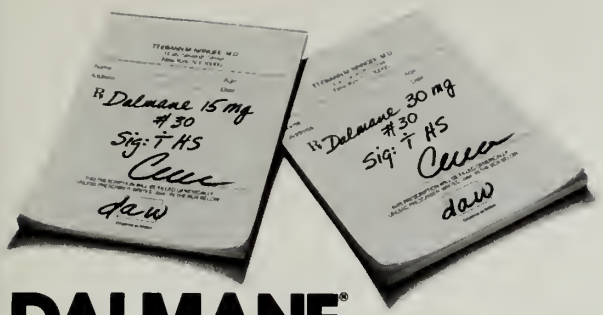
Clinical Update program for spouses . . . The Ohio State Medical Association Auxiliary will offer a program for spouses of physicians who will be attending the OSMA Clinical Update Meeting. The program, "Why Some Physicians' Widows Face Financial Disaster," will be offered on Saturday, November 4 at the Stouffer Dayton Plaza Hotel. The program begins at 8:30 a.m. with a continental breakfast ($5 fee). From 10 a.m. to 1 p.m. attendees will tour local shops and boutiques, and a dutch treat luncheon will be held at 1 p.m. For more information, contact the OSMA Department of Administrative and Educational Services at (800) 282-2712 or (614) 486-2401.

Resident physicians to meet . . . The OSMA Resident Physician Section Annual Meeting will be held October 22, 1989 from 9 a.m. to 5 p.m. at the Marriott North in Columbus. Further details and an agenda will be mailed to all resident physicians. Make plans now to attend the meeting.

OSMA announces support of Caring for Children Program . . . The OSMA will support a new program created by Community Mutual Blue Cross and Blue Shield of Ohio that will provide health insurance benefits to uninsured children in Ohio. Community Mutual has committed to $1 million in funds to match contributions which will be sought from outside groups. Community Mutual will ask participating physicians to accept a reduced level of reimbursement (65% of the usual, customary and reasonable charge for physicians) as payment in full. If a non-participating physician provides services, the enrollee will receive the payment and will be responsible for charges above the Caring Program's allowance. The OSMA will provide members with more information about the program as it becomes available.

Medical writing contest . . . *OHIO Medicine* invites Ohio medical students and residents to enter our first "Medical Writing Contest." A plaque and a $250 prize will be awarded to the medical student/resident who submits the most outstanding scientific paper, as judged by members of *OHIO Medicine's* advisory board. The winners will be announced at the 1990 OSMA Annual meeting in Cleveland. The deadline is February 1, 1990. All entries should be typed, double-spaced and no more than 10 pages. Send entries to: *OHIO Medicine* "Medical Writing Contest," 1500 Lake Shore Drive, Columbus, OH 43204-3824.

Toll-free number . . . Physicians wishing to contact the OSMA on official business may now use the OSMA's toll-free number: (800) 282-2712. If busy, please use (614) 486-2401. We will be evaluating the utilization of these numbers over the next several months.



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References: 1. Kales JD, *et al: Clin Pharmacal Ther 12* 691-697, Jul-Aug 1971. **2.** Kales A, *el al: Clin Pharmacal Ther 18*:356-363, Sep 1975. **3.** Kales A, *et al: Clin Pharmacal Ther 19*:574-583, May 1976. **4.** Kales A, *el al: Clin Pharmacal Ther 32*:781-788, Dec 1982. **5.** Frast JD Jr, DeLucchi MR: *J Am Gerialr Soc 27*:541-546, Dec 1979. **6.** Dement WC, *el al: Behav Med 5*: 25-31, Oct 1978. **7.** Kales A, Kales JD: *J Clin Psychapharmacal 3*:140-150, Apr 1983. **8.** Tennant FS, *el al*: Sympasium an the Treatment af Sleep Disarders, telecanference, Oct 16, 1984. **9.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacal Ther 21*:355-361, Mar 1977.

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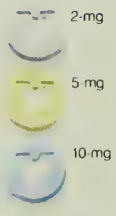

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The Healing Buddha

By Karl Fernandes

Tibetan art has always been closely linked to the religious beliefs of the Tibetan people. Art serves as a conduit for the expression of the innermost self — a way for the Tibetan to physically become closer to his god. The 19th century gilt bronze sculpture, "The Healing Buddha," was a gift of Mrs. Virginia Kettering to the Dayton Art Museum. Although the artist is unknown, like many Tibetan works of art the combined influence of Indian and Chinese styles is evident.

Buddhism originated approximately in the sixth century B.C., and the historical Buddha was actually an Indian prince named Siddharta. According to Buddhist tradition, the sight of a sick man was one of the critical events that led to Siddharta's renunciation of material wealth and his acceptance of asceticism. Although Buddhism in India eventually declined as a major religion, it spread and flourished northward and eastward into Tibet, Nepal, China, Japan and Indo-China.

Buddhism first appeared in Tibet during the late seventh and early eighth century A.D. It was officially established as a religion during the reign of King K'ri sron lde btsan (742-797 A.D.). Tibet served as a springboard for Indian missionaries to spread Buddhism into Asia. The heartland of worship of the Buddha of Healing was in central and east Asia. The "Sutra of Golden Radiance" describes how Siddharta studied all the principles of medicine in order to aid his fellow man. In exchange for food, a Buddhist monk would often serve as a doctor to the laiety. The Buddha was viewed as the supreme physician. Buddhism approaches healing from three points of view. First, disease may be cured through the use of surgery, herbs and foods. Second, there are spiritual causes and cures of disease. Third, physical healing leads to spiritual healing, which leads to spiritual growth.

Due to their austere life and strenuous meditations, monks were especially prone to physical illness and malnutrition. When they took ill, they could not devote all their energy and concentration to their duties. Therefore, Tibetan Buddhism recognized that the maintenance of health is due to the diet. There were five principal medicines: ghee (clarified butter), fresh butter, oil, honey and molasses. Additionally, there exists a pharmacopia of plants and herbs; the names and uses can be found in the Buddhist text the "Vinaya, Mahavagga."

During the early years of Tibetan Buddhism, statues of the Buddha were imported from India by missionaries. The art of decorative metallurgy was well known in Tibet since many weapons of war were decorated with ornate designs. The techniques used for decoration were easily transferred to the religious field. Many bronze statues, sculptures and frescoes were produced by a process that is not fully known.

The 4⅜ inch statue displays typical Tibetan/Chinese facial features, yet the torso stylistically displays more of Indian proportions. The Buddha is clasping what seems to be a small bowl or urn — this would typically be a medicine bowl seen in other sculptures and paintings of the Healing Buddha. Thus, the incorporation of both Chinese and Indian styles and tradition have allowed this Healing Buddha to exemplify the uniqueness of Tibetan art. **OSMA**

Karl Fernandes is a third-year medical student in Ohio State University's College of Medicine, and a member of OSMA's Art and Culture Committee.

References

Raoul Bijnbaum, *The healing Buddha* Shambhala Publications, 1979, 253 pages

Charles Prebish, *Buddhism: a modern perspective,* Pennsylvania State University, 1975, 330 pages

Heinrich Dumoulin, *Buddhism in the Modern World,* Macmillan Publishing, 1976, 368 pages

The Encyclopedia of World Art, Vol. XIV, pg 68-80

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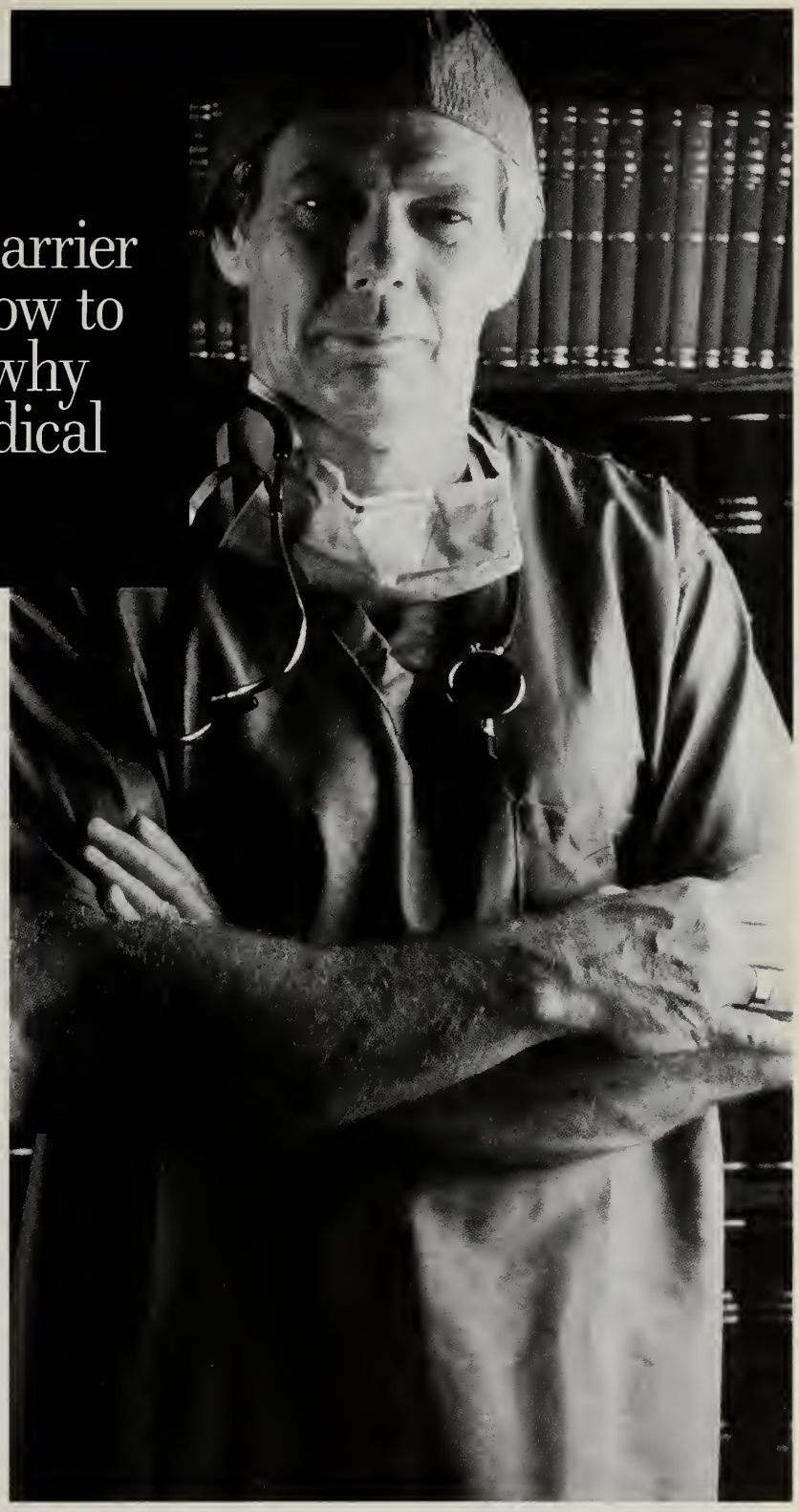

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1989 Subscription: $25 per year.

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FROM THE EDITOR

A Diagnosis Worse Than Death

Alzheimer's disease. The diagnosis seems worse than death, this sentencing of a normal, healthy human being to years of diminishing mental ability. You can offer little in the way of treatment, or even hope for recovery. Instead, you watch helplessly as the disorder grips its victims and slips them slowly over the edge of cognizance, into an abyss deeper, darker and more mysterious than almost anything medical science has tackled to date.

November is the month the Alzheimer Disease Association has set aside as a time to draw attention to itself and the as-yet untreatable brain cell disorder it serves.

Not that Alzheimer's disease is ever far from public thought, however. To generations now familiar with this once-closeted disease, Alzheimer's is a spectre that rises to haunt those shiny, bright promises of lengthy life expectancies. Will I live long enough to be afflicted?, they ask anxiously. The answers are slow in coming.

Our lead feature this month tackles the subject of Alzheimer's disease, and whether or not any progress has been made in learning about this formidable adversary. We've asked experts to provide us with the latest information on diagnosing, treating, determining a cause and finding a cure for AD. We've asked what you, the clinician, needs to know about the disease . . . how to recognize, when to refer, how to treat and what help currently exists for you, the patient and the patient's family. Medicine has come a long way in its understanding of Alzheimer's disease, but it still has a way to go. Perhaps the information contained in this article will help ease the way . . .

The American Medical Association recently created a new department for foreign medical graduates. The department director, John Kasper, who some of you may have met in his previous role as an AMA field representative, has written an article for us about his department's purposes and goals. Even if you are not a foreign medical graduate, his article is worth reviewing . . .

Finally, we want to note that Associate Editor Deborah Athy is leaving the OSMA and the staff of *OHIO Medicine,* after almost five years on the job. Debbie has contributed numerous articles to this publication, and her talents as a writer and editor will be missed.

Next month, we hope to provide you with further information about our readership survey, which we've planned to add to the contents of our January issue. Don't forget, this will be your opportunity to tell us what you'd like to see in future issues of your publication. Watch for it!

Karen S. Edwards

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ISSN 0892-2454
USPS 405-200

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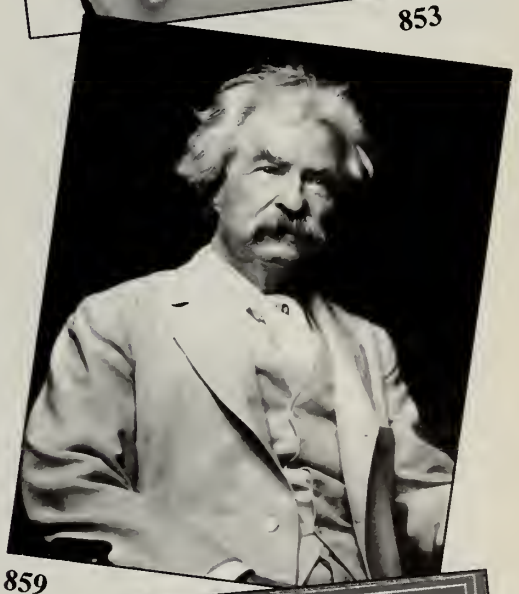

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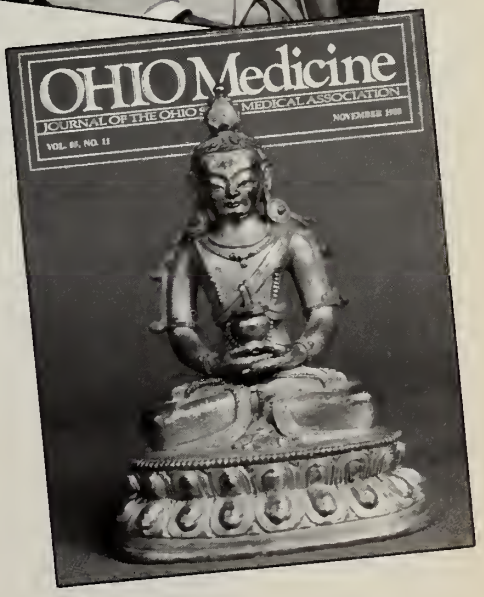

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"Genericgate"

By William J. Marshall, MD
President of the OSMA

Ever since Watergate (1972), writers have chosen to use the "gate" suffix to provide a sinister label to a possible scandal. After Watergate, a scandal in France, which dealt with the adulteration of Bordeaux wines, was called "Winegate." From this point on, it has been common usage to adopt the "gate" suffix as a scandalizer in other fields. Following "Winegate" came "Koreagate." In 1976 it became apparent that an investigation was under way pertaining to corruption of members of Congress by the South Korean CIA. Then there was "Lancegate," "Applegate" and "Floodgate." I will not bore you with the details of the last three "gates," but it is apparent how useful the "gate" construction has become to writers.

With all of the above in mind, and after careful study of the recently revealed generic scandals, I felt it appropriate to label this latest example of corruption "Genericgate."

As is typical of most scandals, everyone who has had a finger pointed at them in this latest "gate" has pointed their finger at the next person. Dr. Frank E. Young, commissioner of the Food and Drug Administration for the past five years, has been criticized. Some members of Congress have been critical of Young's FDA, but we should remember that since 1981 Congress has passed 23 bills increasing the FDA's duties, while simultaneously reducing its staff from more than 8,100 to about 7,400.

State legislatures have also been active participants in the last decade's rush to generics. During the 1960s and 1970s, all 50 states repealed anti-substitution laws, which up until then had prohibited alternative dispensing of prescription drugs by pharmacists. Since these changes in the laws have occurred, states in various ways have encouraged substituting generic drugs for brand-name products.

Enthusiasm for prescribing generic drugs has never been universal amongst physicians. Many have complained, regardless of the assurances, that not all generics have the same affect as their brand-name counterparts. With the latest scandal, physicians' confidence in generics will continue to erode.

The public — our patients and the government's consumers — have for the most part been trusting, clearly lacking understandable information, but willing to listen to their physicians and share with them variations in their response to generic and innovator drugs. These encounters have raised the bioequivalence issue in an anecdotal way. The FDA's reporting procedures do not make it easy for the physician to document variations in drug response within the same patient. The process must be simplified for physician and patient so that better documentation is available as we attempt to compare medications in the clinical setting.

This summer the generic vs. brand-name drug debate reached a new plateau. In May 1989, Rep. John D. Dingell (D-Michigan), chairman of the House Energy and Commerce Committee, held hearings, after which two generic drug manufacturers withdrew their products from the market following allegations of irregularities in testing data provided to the FDA. This investigation has now resulted in 26 recalls and 141 suspensions of generic products. At least five companies have been incriminated — Par Pharmaceuticals, Inc.; Vitarine Pharmaceuticals, Inc.; American Therapeutics, Inc.; Barre-National; and Superpharm. In addition, Bolar Pharmaceutical Co., Inc., has been alleged to have substituted a brand-name anti-hypertensive in place of its own drug as it sought FDA approval. Just preceding these revelations, it

"We, as prescribing physicians, need to carefully consider and more energetically use our legal right to control the medications our patients receive . . ."

was announced that the U.S. Attorney in Baltimore is investigating a series of payoffs made by generic makers to FDA chemists instrumental in approving drugs. At this point, three FDA employees have been indicted and two have pleaded guilty.

Much of the criticism in recent weeks has centered on the FDA and its commissioner. Dr. Young has warned that if the generic drug scandal worsens "there is a real possibility that the generic drug industry may be totally discredited." Further, in answer to a memo written to Health and Human Services Secretary Louis Sullivan in July, Young said, "I am disturbed about the corrupt and fraudulent behavior within the generic drug industry, as well as the apparent breakdown in the 'honor system' on which the generic drug review process is, in part, predicated." The ability of the FDA to do its job has been seriously challenged. Rep. Dingell said, "Clearly he has a great deal to do to correct his agency . . . (The FDA commissioner) "will be judged by how well he addresses the problems" his agency faces.

It would seem almost fortuitous that two years ago the American Academy of Family Physicians (AAFP) started a study of generic products. This task was given to its Drug and Devices Committee, chaired by Jerry Mann, MD. Its report has just been released after being accepted by the AAFP Board. The full report will be presented to its membership of 60,000 family physicians in September 1989, and they will be asked to vote on the report. This "White Paper" will be appreciated by all physicians but only adds more controversy to that already surrounding the generic drug industry.

The AAFP's report confirms what many physicians and some of our patients have suspected all along. The report says: "Bioavailability does not necessarily equal therapeutic equivalence." Further, the report says, "There is much evidence in the medical literature which indicates that many so-called generic substitutes are not chemically the same drug entity in the same dosage form."

While all this furor continues to boil, we, as prescribing physicians, need to carefully consider and more energetically use our legal right to control the medications our patients receive by adding "D.A.W." (dispense as written) to our prescriptions *in our own handwriting.* This law was recently brought into question on August 1, 1989 when the Ohio Bureau of Workers' Compensation started a new progran intended to increase usage of generic drugs among workers' compensation patients. The bureau now requires that, in addition to D.A.W., the physician must also attach a short statement to the prescription explaining the medical necessity for the brand-name medication. This is simply another bureaucratic method of rationing through inconvenience by enhancing procedural complexity, and it should be challenged by organized medicine. We must ask our patients to open and look at the contents of all new prescriptions and tell us immediately if substitution has occurred. According to the AAFP report and other reports in the professional literature, patients with convulsive disorders, diabetes mellitus, psychoses, congestive heart failure, arrhythmias and other heart problems, asthma and depression should not be prescribed generic drugs. At the state level, through our legislative committee, we need to review Ohio's laws regarding drug substitution and suggest methods to strengthen them. OSMA should initiate dialogue with the Ohio Pharmaceutical Association and discuss the issues of generic substitution. In Washington, D.C., Congress is considering the need for additional legislation to correct some of the abuses Rep. Dingell's committee has uncovered. The Inspector General's Office has completed a review of the FDA, which revealed it did not have adequate internal controls over the generic drug review process to maintain its integrity. Rep. Tom Bliley (R-Virginia), of the House Subcommittee on Oversight and Investigation, said, "The report confirms that there are serious weaknesses in FDA's generic drug review process. The problems are not isolated as some in the agency originally contended."

As the extent of "Genericgate" is exposed over the next few months, we must do everything in our power to protect the public — our patients — and to make sure they receive safe and effective medications. In Ohio, for the practicing physician this means using the power of *your* pen as you write a prescription by adding D.A.W. (dispense as written) in the office as well as the hospital. **OSMA**

Commitment to Community Service

Barbara Marshall, President, OSMA-A

By Barbara Marshall

The Ohio State Medical Association Auxiliary has a long commitment to improving health and quality of life. Our county auxiliaries are engaged in many activities that benefit their communities. Following is a brief description of just a few of those projects.

This fall the Montgomery County Medical Society Auxiliary will distribute 10,000 health-care resource guides for teens entitled "Pick Up the Direct Line." Intended to help teens identify problem areas and find help, the guide contains brief, easy-to-read capsules on medically oriented subjects, followed by a listing of county agencies and phone numbers to call for additional information and help. An alphabetical index offers more detailed information on agencies, such as hours, fees and whether an appointment is required. The booklet is the result of a year of planning during which auxilians met with county health professionals and school administrators to define areas of interest and concern to teens. County agencies were surveyed to determine what services they offered to this age group and then visited by auxiliary volunteers who obtained further details. Geared toward seventh-graders, the booklets may also be given to other grades at the discretion of school officials.

A recent ABC news special, "Survival Stories: Growing Up, Down and Out," focused on six of the problems facing our youth and solutions that some communities have found. As part of a larger program, "Making the Grade: A Report Card on American Youth," communities across the country were urged to come together to discuss these issues on a local level. Accepting this challenge, the Scioto County Medical Auxiliary, together with the Teen Health Task Force, convened a town summit meeting on September 28 to discuss how teens in their county were affected by teen pregnancy, functional illiteracy, school dropouts, substance abuse, juvenile crime and youth unemployment. This was followed by a Health Fair, featuring 25 exhibits, held at the Scioto County Joint Vocational School on October 16. At the end of the day, a final report on "Making the Grade in Scioto County" was distributed and discussed. A panel discussion focused on one specific issue, teen pregnancy. These programs of the auxiliary were well received and have given direction on specific issues to the schools, agencies and medical community in Scioto County. (Note: Town summit meetings were also convened by the medical auxiliaries in Lawrence, Seneca and Trumbull counties.)

A major project of the Stark County Medical Society Auxiliary is the Domestic Violence Project Transitional House, also known as the "House of Hope." Donated by a local church, it serves as a temporary home for abused women and their children during their "transitional phase" following their stay at the Domestic Violence Shelter. From the transitional home the women attempt to re-establish permanent residence elsewhere. The auxiliary undertook the task of furnishing the house. It solicited monetary donations and compiled a wish list of used items. In less than six months the entire three-bedroom house was furnished, complete with security system. This year, the auxiliary will begin phase two of the project, which is to provide each woman who leaves with a

"The long-range goal of the (Trumbull County) program is to enable students to develop responsible behavior, self-esteem and respect for others as they make decisions involving the use of their sexual freedom."

"starter package" of necessary supplies for housekeeping and some personal care items.

Seeing premarital sex as a medical issue, the Trumbull County Medical Society Auxiliary introduced SEX RESPECT to their community at "Healthwise 88," an annual health fair. This abstinence curriculum, developed four years ago with a grant from the Department of Health and Human Services, has been used in a number of schools in six Midwestern states. The long-range goal of the program is to enable students to develop responsible behavior, self-esteem and respect for others as they make decisions involving the use of their sexual freedom. The auxiliary has provided the necessary teaching materials, purchasing four-part videos entitled "Everyone is NOT Doing It" for loan to schools, churches, scouts and community groups. The seven public libraries in Trumbull County have been given sets of manuals for child, parent and teacher in addition to the videos. The auxiliary is also underwriting a national speaker from SEX RESPECT to conduct in-service training for teachers in all county schools.

These are but a few of the many projects developed by county auxiliaries in Ohio to meet the needs of their own community. For further information on these and other programs, contact the OSMA Auxiliary. **OSMA**

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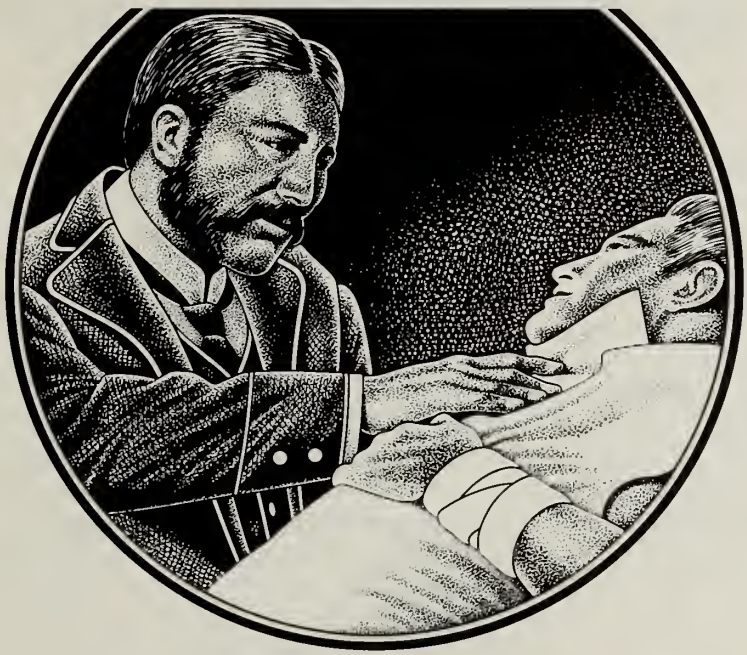

He Makes a House Call

By John Stone, MD

Editor's note: *John Stone, MD, is a noted poet, author and physician. Presently associated with the Emory University School of Medicine in Atlanta, Georgia, Dr. Stone has written three books and authored numerous articles for the* New York Times *magazine (one of his* Times *articles will be featured next month). This past spring, Dr. Stone received an honorary degree, Doctor of Humane Letters, from the Northeastern Ohio Universities College of Medicine, Rootstown, Ohio. The following poem has been reprinted from Dr. Stone's book, "In All This Rain," published by the Louisiana State University Press.*

Six, seven years ago when
you began to begin to faint
I painted your leg with iodine

threaded the artery
with the needle and then the tube
pumped your heart with dye
    enough

to see the valve
almost closed with stone.
We were both under pressure.

Today, in your garden
kneeling under the sticky fig tree
for tomatoes

I keep remembering your blood.
Seven, it was. I was just
beginning to learn the heart

inside out.
Afterward, your surgery
and the precise valve of steel
and plastic that still pops and clicks
inside like a ping-pong ball.
I should try

chewing tobacco sometimes
if only to see how it tastes.
There is a trace of it at the corner

of your leathery smile
which insists that I see inside
the house: someone named Bill
    I'm supposed

to know; the royal plastic soldier
whose body fills with whiskey
and marches on a music box

How Dry I Am;
the illuminated 3-D Christ who
    turns
into Mary from different angles;

the watery basement,
the pills you take, the ivy
that may grow around the ceiling

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Guest Editor . . . *continued*

if it must. Here, you
are in charge — of figs, beans,
tomatoes, life.

At the hospital, a thousand times
I have heard your heart valve
open, close.
I know how clumsy it is.

But health is whatever works
and for as long. I keep thinking
of seven years without a faint

on my way to the car
loaded with vegetables
I keep thinking of seven years ago
when you bled in my hands like a
saint.

Next month in OHIO Medicine

- **The 1989 Legislative Year in Review . . .**
  A look at all of the medically and health-related legislation introduced to the Ohio Legislature this year — and where these bills stand now.

- **Ohio Physicians' Attitudes About Treating AIDS Patients**
  A survey conducted by the Ohio Department of Health offers revealing information.

LETTERS TO THE EDITOR

On cholesterol testing of children . . .

To the Editor:

I was alarmed to read the short article on cholesterol testing of children (*OHIO Medicine,* August 1989). My concern is with the use of the total serum cholesterol (CT) as the screening tool. I have written to *OHIO Medicine* before, proclaiming the ill-advisedness of using CT to screen adults for the lipid portion of atherosclerotic disease (ASD). The inappropriateness of using CT in adults is compounded in children. Children typically have high high-density-lipoprotein cholesterol (HDL) levels which, in the borderline CT levels of 176-200 mg/dl and perhaps higher, may well account for the "high" CT. Therefore, the prudent thing to do is to order a lipid profile (to include HDL and LDL [low-density-lipoprotein cholesterol]) BEFORE ANY DIETARY TREATMENT IS EVEN CONTEMPLATED. High levels of HDL do not constitute a risk of future ASD and in fact may protect against it. Why then would any physician wish to lower a child's CT when that elevated CT is due to HDL?

On the other hand, use of CT as a screening tool in children will miss any children with low HDL levels and thus an important group of future ASD candidates. Therefore, why not use a full lipid profile to begin with? This will avoid treating children who do not need to be treated and will pick up those children who are at risk due to low HDL. Surely this must be the better way to go, and just as surely the continued use of CT must remain "a step back into the Dark Ages."

W.E. Feeman Jr., MD
Bowling Green

Balancing the evaluation

To the Editor:

As a long-time student of the Canadian and American health-care systems — on the programmatic and political levels — I was dismayed by the tone and substance of the three articles in the August edition. The polemical style adopted by all three authors is an indulgence we can no longer afford. The ancient bogeymen are invoked including "socialized medicine," "an army of administrators and regulators" and "regimentation." The pragmatic and low-key tone of President Marshall's remarks are in sharp contrast to these polemics.

Substantively, the "facts" emphasized in the articles serve only to divert attention from the difficult trade-offs inherent in any comparative health policy analysis. For example, the authors' focus on tertiary care cases in Canada, rather than primary care services, strikes me as designed to divert analysis from a health-care service area where the U.S. may be most susceptible to criticism. John Budd offers a statistical analysis of overall health costs in the two societies which is at best misleading. He confuses national budgets with gross national product (GNP) measurements and seems not to understand that the 8.6% of GNP spent for health care in Canada (vs. 11%-12% in the U.S.) in fact *includes* national, provincial *and* private expenditures. Additionally, there is no comparison of the Canadian per capita expenditure for health care with the U.S. per capita expenditure through both taxes and premiums, only an unsubstantiated implication that Canada's taxes are excessive.

In short, I am pleased to see attempts to do comparative health policy analysis, but I believe the policy debate in our country is ill-served when the analysts are driven by the desire to inflame the passions of partisans rather than to offer sober and balanced evaluations.

Craig Ramsay
Dublin

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OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians

Cholesterol Coverup?

The American Medical Association, the U.S. government and drug companies were taken to task in the September issue of *Atlantic Monthly* for their participation in a national cholesterol campaign. The article, written by Thomas J. Moore, reports that millions of Americans are misled about the health benefits of lowering cholesterol and that one of the reasons the AMA became involved in the campaign was the benefit its members would receive from the large number of additional laboratory tests and office visits that a Campaign Against Cholesterol program might create.

The article also says:

- No clinical trial has produced evidence that lowering cholesterol will save or extend lives, despite attempts in five countries over two decades.
- Strict dieting doesn't lower cholesterol by significant amounts, a seven-year government trial with 12,000 participants showed.
- Those who suffer early heart attacks do not eat more cholesterol, saturated fat or overall calories than those free of coronary heart disease, according to a government study of more than 16,000 men.
- Cholesterol-lowering drugs have been linked to liver damage, cancer, gallstones, cataracts and increased numbers of heart attacks.
- Millions of people will be treated for high cholesterol by mistake because of inaccurate laboratory tests.
- Low cholesterol levels have been associated with increased risk of cancer, stroke and gallstones.
- One reason why Americans hear so much about the dangers of cholesterol is because of a little-known U.S. government program designed to put one-quarter of the adult population under medical treatment.

Ohio parents speak out

Day care emerged as the leading concern of parents in a 17-county survey of public opinions toward children's issues, recently conducted by the Children's Hospital Medical Center of Akron.

Of the more than 800 northeast Ohio parents or legal guardians of children under 18 contacted for the survey, at least 60% indicated that day care should be a top priority for government legislation.

In other issues:

- four of every 10 respondents indicated that business and industry should pay for child medical care if the child's family is unable to pay.
- the question of whether or not paddling should be allowed in schools was split 50-50.
- one-third of the respondents disagreed that sex education in schools should be available regardless of parental consent.

Cost-conscious medical group is forming

A Pittsburgh, Pennsylvania physician is organizing a new physician group, dedicated to dealing with "the current cost crisis in American medicine."

Physicians for Research in Cost-Efficiency (PRICE) will facilitate communication on low-cost quality medical information among physicians involved in research, academia, administration and practice, says founder David J. Shulkin, MD.

"Many of us are involved already in efforts to facilitate the development of cost-effective medical practice," says Dr. Shulkin. "We must now begin to use this information effectively."

A newsletter will provide information on research efforts, political trends and clinical observations, as well as innovative suggestions for the practice of cost-effective care. In addition, PRICE will serve as a clearinghouse for conferences, new job opportunities and training options for physicians interested in cost issues in medicine.

Interested physicians can contact David J. Shulkin, MD, President,

PRICE, 926 Bellefonte St., Pittsburgh, PA 15232, (412) 682-8015 for more information.

Producer searching for young MDs

How old were you when you received your medical degree? If the answer is "young" — somewhere between 16 and 18, perhaps — the producers of a new television show, "Doogie Howser, MD" (which, given the current instability of most television series may or may not be on the air by the time this sees print) would like to know about you.

"Doogie Howser, MD" traces the fictional trials of adolescent physician Doogie Howser who graduated from Princeton at 10 and collected his medical degree at 14. By the time the show catches up with him, he is in his second-year residency at a Los Angeles medical center.

Steven Bochco, producer of "Hill Street Blues" and "L.A. Law," is searching for a real-life "Doogie" — someone who began practicing at a very early age. If you think you qualify, contact James A. Gordon, Vice President, Public Relations, Steven Bochco Productions, 10201 West Pico Boulevard, Los Angeles, California 90035.

Of course, only the very young need apply . . .

Above: The cast of "Doogie Howser, MD." Producer Steven Bochco is looking for a real-life "Doogie."

Lack of birth control options may spur abortion debate

The issue of legalized abortion can only grow worse as the continued lack of birth control options means that steady — not decreasing — numbers of abortions will be performed each year.

That's the opinion of Carl Djerassi, professor of chemistry at Stanford University, also known as the "father of the birth control pill." Djerassi recently criticized the American pharmaceutical industry for abandoning its research into new methods of birth control.

"Many people ignore the fact the incidence of abortion reflects the state of contraception," he says.

The industry's fear of legal litigation in product liability suits is being blamed for the dearth of research efforts in this area, and Djerassi predicts that until Congress modifies its strict liability of manufacturers for new contraceptives and vaccines, preferably with a no-fault insurance program, research will continue to remain at a standstill.

If research were to continue, however, what direction would it take?

Djerassi says top priority should go to the development of a new spermicide with anti-viral properties. Second priority would go to a once-a-month pill that women would take to induce menstruation only during those months when they had unprotected sexual intercourse. Other research that might be considered include:

- a reliable test for predicting ovulation that could be used by couples practicing the "rhythm" method.
- a reliable and easily reversible method of male sterilization
- a male birth control pill
- an anti-fertility vaccine

Djerassi emphasizes, however, that even if research and development on new contraceptives began tomorrow, no new method could be available for 12-20 years.

Dyazide generic approval withdrawn; battle between generics and brand-name drugs heats up

As the U.S. Food and Drug Administration withdrew its approval of the last remaining generic version of Dyazide, the leading drug used to control hypertension, it stated that it is no longer certain that the generic is equivalent to the brand-name drug.

The FDA statement promises to heat up the battle between generic and brand-name drug companies that has been threatening to flare up for years.

At stake is the $20-billion-a-year prescription drug market which belonged almost exclusively to brand-name manufacturers until rising pressure to control health-care costs allowed generic firms to corner larger and larger shares.

Approximately 30% of prescription drug revenues presently belong to generic companies, and analysts predict that percentage could rise as high as 65% by 1995.

However, the FDA's recent withdrawal of approval, as well as a lack of confidence in generics expressed by a growing number of physician and consumer activities, could affect that prediction, as well as the future of the generic drug market.

While there is no evidence — no scientifically documented cases — that generic drugs have caused any harm to patients, federal investigations, prompted by reports of corruption in the generic drug industry, continue.

COLLEAGUES

ROSS R. BLACK II, MD, Cuyahoga Falls, has been installed as vice president of the Ohio Academy of Family Physicians . . . **WILLIAM A. SMITH, MD,** Columbus, has been promoted to senior vice president of medical affairs at Peer Review Systems, Inc. . . . **JEROME STANISLAW, MD,** Warren, has been elected a trustee of District 5, Ohio Division of the American Cancer Society . . . **DANIEL NIEHAUS, MD,** Hamilton, has been elected president of the Hamilton-Fairfield Area Academy of Medicine . . . **DAVID M. MONTGOMERY, MD,** Canton, has been appointed chief medical officer of the Emerald Health Network . . . **RANDALL R. WROBLE, MD,** Cincinnati, is one of four orthopaedic surgeons in the country to receive the North American Traveling Fellowship. The award is one of the highest honors for a young orthopaedic surgeon and is sponsored by the American Orthopaedic Association . . . **CHARLES E. CASTO, MD,** Stow, has been named Family Physician of the Year and **LAUREN BROWN, MD,** Westerville, has been named Ohio Family Practice Educator of the Year. Both physicians were honored during the Ohio Academy of Family Physicians annual meeting . . . **CARL CHUDNOFSKY, MD,** Cincinnati, has received the Academic Excellence Award from the Emergency Medicine Residents Association . . . **GERMAINE HAHNEL, MD,** North Olmsted, has received the Outstanding Woman Physician Award from the Women's Medical Society of Cleveland . . . **LEWIS B. MORROW, MD,** Toledo, has been appointed acting medical school dean and vice president of academic affairs at the Medical College of Ohio . . . **ROBERT REED, MD,** Cincinnati, has been elected to the board of trustees of the American Heart Association, Cincinnati area . . . **ROBERT D. LERNER, MD,** Cincinnati, has been appointed medical director of Geriatric Programs at The Jewish Hospital . . . **JAMES KVALE, MD,** Youngstown, has been named medical director at Park Vista Retirement Community . . . **JEFFREY L. SCHNEIDER, MD,** Cincinnati, has received the Blankenhorn Society Award from the University of Cincinnati Medical Center for his "continuing excellence in the teaching of internal medicine" . . . **EDWARD CHARNOCK, MD,** Cleveland, has been elected president of the American College of Emergency Physicians, Ohio chapter . . . **FRED M. LAMPRICH, MD,** Youngstown, and **PAUL E. KRUPKO, MD,** McDonald, have been honored by the Ohio Academy of Family Physicians for 50 years of medical service . . . **WILLIAM FARRAR, MD,** Upper Arlington, has been named medical director of the Columbus Cancer Clinic . . . **LEOPOLD LISS, MD,** Columbus, and **SHERRY STANLEY, MD,** Dayton, have been reappointed by Gov. Celeste to the Alzheimer's Disease Task Force . . . **EDWARD A. MORTIMER, MD,** Cleveland, has been elected as a senior member to the Institute of Medicine, which was founded by the National Academy of Sciences in 1970.

Randall R. Wroble, MD . . . one of four orthopaedic surgeons around the country to receive a North American Traveling Fellowship.

OHIO MEDI-SCENE

Reducing foreign accents . . . Medicaid tips . . . international residency program . . . honors for a retiring chairman . . . auxiliary directs attention on teens . . . guidelines for physicians of athletic teams . . .

Reducing foreign accents

"We'd be happy to send you that brochure, sir," says the efficient voice on the other end of the phone. "Could you give me your address, please?"

There is a long, embarrassing pause before the reply.

"It's skix-oh-nine Main Street."

This time the operator pauses.

"Would you repeat that sir . . .?"

Anyone with an accent — foreign or domestic — will tell you there's a lot of repeating, even spelling, when any type of oral exchange occurs. It's difficult enough when simple, day-to-day exchanges, such as the one above, are involved, but when you're a physician, trying to make yourself understood to a patient, that telltale accent can become a hindrance — no matter how proficient in English you are.

Enter Susan Saltzman.

Saltzman is a speech therapist who has started a Foreign Accent Reduction program at the Cleveland Hearing and Speech Center. She talks without any discernible accent, yet she was born in Sweden, and learned Polish as her first language.

"My parents are Polish, and I grew up surrounded by accents," she says.

Yet accents were simply not something one bothered about — especially speech therapists — until the early 1970s.

Before that time, Saltzman explains, foreign-born nationals

Reducing foreign accents . . . *continued*

stayed together in close-knit, ethnic communities. Accents were bonds, not something to be carefully cultivated out of existence.

After the '70s, however, things changed. The Vietnam War ended. Japan became a world power.

"Suddenly, America was receiving an influx of people from Asia," Saltzman says. Not all of these were refugees, seeking to flee their war-ravaged country. Many were students, and many more were businessmen.

"Business has become international in scope these days," Saltzman observes, and Cleveland has become home to a number of businesses that have stretched across oceans for their top-notch executives and other professionals. Add to that a number of foreign-born students enrolled in Cleveland-area universities, and you have the reason Saltzman started her program this past February.

The participant makes up sentences from the words . . . "That's where the grammatical mistakes show up . . ."

She has had eight clients — "so far" — but that number is bound to increase soon, as St. Luke's Hospital has contracted with Saltzman and the center to send all of its foreign-born pediatric residents through the foreign-accent reduction program.

"Most foreign-born physicians seem to be in pediatrics or internal medicine," Saltzman says. "And a large number of them are involved in research. In the laboratory, they don't have to say much."

But for those physicians who do have to communicate regularly to colleagues, staff and patients, the foreign accent reduction program can make the task easier.

Potential participants in Saltzman's program should have a level of English that enables them to converse easily, and they should be able to read an English newspaper — roughly the equivalent of reading at a sixth-grade level.

"Don't forget, though, that generally I'm dealing with high-level professionals — physicians and college graduates," says Saltzman, so the criteria to enter the program has not yet proven to be a stumbling block.

Once accepted, Saltzman conducts a short interview with the participant.

"At this point, I'm listening to how they sound," she says.

She has the participant read a few words, then make up sentences from the words.

"That's where the grammatical mistakes show up," she continues.

Then, the participant is asked to read a passage from a book or a newspaper. Finally, Saltzman engages her client in light conversation.

From these simple exercises, Saltzman makes out her evaluation, noting any pattern of errors — in grammar, pronunciation or rhythm — that cropped up during these preliminary tests.

Then, a course of action is decided.

Saltzman works with each client individually, basing much of her therapy on the work of Arthur Compton, a California linguist and speech therapist.

"I didn't come up with this program all by myself. I've certainly added my own sections, based upon my clients' needs and my own experiences, but I wanted to go with a program that has already proven itself," she explains.

From Compton's program, she draws the manual and the pre-recorded tapes that are sent home with each participant.

"Practice is a large part of reducing accents," Saltzman points out. The more participants work — on their own — at reducing those nuances that make their speech "foreign," the better chances are of making themselves more easily understood.

Those nuances can be almost anything — depending, to a large extent, on the client's nationality and his or her experience learning English.

"Those who learned English in elementary school believe they're ahead of the game, but if they were taught English, as most were, by someone from their own country, the sounds that make them different were reinforced in these classes."

In fact, Saltzman has been told, in many of these foreign-taught

English classes, English was barely spoken.

"My clients tell me they did the work and went back to speaking their own language."

What Saltzman attempts to do in her program is to make these foreign nationals aware of the sounds they're making and how those sounds are different from Americans' speech. Then, she encourages them to monitor themselves against these sounds.

"In general, 'r' is the toughest sound to master," she says. "Almost every language in existence has an 'r' sound, but it exists in different places in the mouth." Consider the trilling, rolling "r's" of the Spanish language and compare it to the back-of-the-throat "r's" of Germany, and you'll better understand the difficulties of speaking flawless English.

Other accents substitute sounds — "v" for "w," for example (as in "ve vent to the store") and "z" for "s" (i.e. "zizzors" for "scissors").

Then, there's the "th" sound.

"As far as I'm aware, this sound doesn't exist in any other language, anywhere," says Saltzman.

The sound comes automatically to born-and-bred Americans, but just the thought of creating the sound can cause consternation for some foreigners.

"I've had one client tell me, 'I can't do that. I can't stick out my tongue like that,' " Saltzman says with a laugh. Eventually, she was able to persuade the participant that there is nothing demeaning about it.

Ravi Paul, MD, director of Adolescent Medicine at St. Luke's Hospital in Cleveland, found himself having to work on "r's," substituting "v's" for "w's" and the "th" sound when he signed up for Saltzman's program.

"Before (the program), I would say I didn't have a problem. I didn't realize that patients were having difficulty understanding me," he says now.

As a native of India, he knew there were certain words that gave him difficulty, and his American wife had told him on several occasions that there were some words he said that could be improved. Attempting to correct his accent himself, however, proved frustrating, and when he came across a brochure on Saltzman's new program, he signed up for it eagerly.

It's been hard work — "It took me two hours to make that "th" sound," he confesses — but he finds he's now better able to communicate words like "bath," "thinking" and "thank you." And, when he calls his patient "Ruth," it no longer sounds like "root."

"I've learned to slow down when I talk. Most foreigners speak very fast because our language is spoken very fast, but if I slow down, there is better understanding," says Dr. Paul.

There is also a better chance that he'll catch any errors he hears himself making.

Dr. Paul spent eight weeks in the program. Most spend 13 weeks — comparing how they sound to the target "American sound." They practice until they reach it, or get considerably closer to it. Then they go over their sentence rhythms, their intonations, their phrasing and pronunciation, all the time practicing and monitoring themselves.

"Most do improve their accents by at least 50%," says Saltzman, "but I tell them the burden is on them to keep improving. They have to continue to work on it."

Saltzman incorporates a three-month follow-up into her program. The total package, complete with tapes and workbook, amounts to $875.

"The cost may explain why we haven't had any laborers or factory workers enter the program," Saltzman admits. Still, the cost doesn't seem prohibitively high for companies looking to put some polish on their top-level executives, or for a hospital that wants its pediatric residents to communicate more effectively with patients and their families.

"The client increases self-confidence, no doubt about it," says Saltzman. She points to one program participant who will be giving a seminar next week in front of hundreds of professionals . . . something the client probably wouldn't have thought about doing prior to the program.

But public speaking isn't the only advantage the client reaps from improved English.

"I tell them I'm not trying to erase their accents, I'm not trying to turn them into native speakers," says Saltzman.

But sometimes, it's nice just to be able to give an address to the person on the other end of the phone — and not have to repeat it. — *Karen S. Edwards*

OHIO MEDI-SCENE

Medicaid tips

The Ohio Department of Human Services makes changes in the drug formulary quarterly. Most of the additions and the deletions are based on recommendations presented by the Pharmacy and Therapeutics Committee. The Committee is composed of Janet Bixel, MD; Charles May, DO; James Visconti, PhD; Suzanne Eastman, RPh, MS; Mary Ann Waltenbaugh, RN; and Robert P. Reid, RPh, Chairman. For your information, the following changes will appear in the November 1, 1989 update:

Trade Name Additions — New Drugs

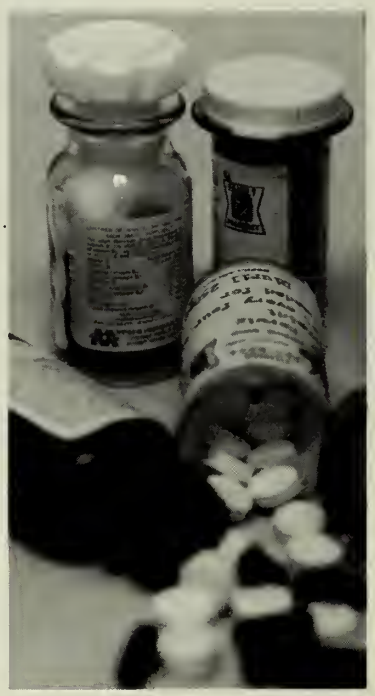
Cardizem SR 60mg; Cleocin T Lotion; Cylert Chewable 37.5 mg; Cytovene Inj 500 mg/10ml; Elocon Lotion; Estratab 0.3mg, 0.625 mg, 1.25 mg, 2.5 mg; Exelderm Cream, Soln; Golytely Soln; Humulin 70/30; Ifex/Mesnex 1 Gm/200 mg; Loprox Lotion; Lysodren 500 mg; Mesnex 200 mg, 400 mg inj; Mexate AQ inj; Mixtard Human 70/30; Novafed; Paraplatin inj 150 mg; Slo-Bid 75 mg, 125 mg; Sudafed 120 mg; Suprax 400 mg, 100 mg/5 ml; Tolectin 600 mg.

Trade Name Additions — Line Extensions

Actigall 300 mg; Cytotec 200 mcg; Nasalcrom; Slow-K; Ten-K; Theo-dur 200 mg, 300 mg; Transderm Nitro.

Generic Additions

Cefadroxil Susps; Cyclobenzaprine 10 mg;



Erythromycin 250 mg caps; Fluocinonide-E Cream; Irrig Soln Sorbitol; Magnesium Gluconate 500 mg; Morphine Sulfate Conc Solns 10/mg/ml, 15 mg/ml, 30 mg/ml; Niacin SR 500 mg; Prazosin 1 mg, 2 mg, 5 mg; Propranolol ER 60 mg, 80 mg, 120 mg, 160 mg; Timolol 5 mg, 10 mg, 20 mg; Verapamil 40 mg.

Deletions — Discontinued Drugs

Azactams (some); Barseb HC; Bi-K; Brompheril; Calan SR 240 mg (60's only); Conceptrol; Crystodigin 0.05 mg, 0.15 mg; Isordil Chewable 10 mg; Komed HC; Labid; Phazyme PB; Ramses Vag Jelly; Somophyllin 105 mg/5 ml; Tandearil; Velosef inj 4 Gm; Wigrettes 2 mg. — *Robert Reid, RPh; Janet Bixel, MD*

Residency program goes international

The U.S. armed services may have to use such catchy slogans as "See the world" and "Visit foreign countries" as a means to lure volunteers, but a new residency program in Cleveland certainly hasn't had any trouble attracting candidates.

According to Jeffrey Goldhagen, MD, a Cleveland pediatrician and an assistant professor of pediatrics at Case Western Reserve University (CWRU), "The interest in the program has been dramatic with respect to resident candidates. We had *hundreds* of inquiries before it started. People are obviously committed to seek answers to the problems and challenges of international health."

What the residents were interested in is the new Pediatrics and International Child Health residency program offered by the School of Medicine at CWRU and Rainbow Babies and Childrens Hospital.

The program, which began in July, offers pediatric residents a chance to study global maternal and child health problems and systems of health-care services in Central America, Africa and Asia.

The initial idea for the program came about because "At Case Western Reserve University," Dr. Goldhagen explains, "the medical school has inaugurated a center for international health. The intent of the center is to link the resources in the university and to develop a multidisciplinary program to address issues pertaining to global

health." Dr. Goldhagen also adds that William Speck, MD, chairman of the Department of Pediatrics, has been instrumental in the development of the center and residency program from their inception.

The reasons for developing the program are varied, but "Basically the issue is that close to 90% of children are born in developing countries," says Dr. Goldhagen. "It's important to become familiar with their problems if we are to consider ourselves well-trained child health specialists.

"The other aspect," he continues, "is that developing countries have as much to teach us as we have to offer them."

For example, says Dr. Goldhagen, "much of what is learned in developing countries may be applied to the care of children in this country, especially those who come from communities with limited resources, that is, urban centers, rural areas, Indian reservations . . ."

Explaining the program's intent and getting accepted into the program, however, are two different things. Students interested in participating will soon learn that the competition is steep — the school, as Dr. Goldhagen mentioned earlier, received hundreds of inquiries about the program, but only five residents will be chosen each year.

"Developing countries have as much to teach us as we have to offer them"

Participants are chosen for a variety of reasons, but Dr. Goldhagen notes that students interested in pursuing a career in developing countries are not given preferential treatment.

Jeffrey L. Goldhagen, MD is a pediatric specialist in international health at the Rainbow Babies and Childrens Hospital in Cleveland.

"The program is not meant to only serve those people interested in international health," says Dr. Goldhagen. "It's meant to increase the breadth of knowledge and skills required to care for children in communities and cultures that differ from our own. This is true whether those communities are in Central or South America, Africa, Asia, Cleveland or Appalachia."

A candidate who *is* accepted into the program can expect to spend four to five years in residency, as opposed to the three of a normal pediatric residency, says Dr. Goldhagen.

During the first year, residents are exposed to the history and health and culture of developing countries. "It's really meant as an orientation year," says Dr.

OHIO MEDI-SCENE

Residency program goes international . . . *continued*

Goldhagen, "and also to introduce them to the broad range of activities encompassed by international health."

During the second year, residents spend eight weeks abroad, with the intent being "for them to introduce themselves to a community and learn about its culture and health problems," he says, adding that residents have a say as to what country they will be visiting and thus, the opportunity to study in an area they're most interested in, such as refugee medicine.

During the third and fourth years, residents go abroad again — preferably to the area to which they were first assigned — for about six to eight months.

During the fifth year, which is optional, residents may choose to pursue a masters degree, begin a PhD program or continue with international fieldwork.

Residents, by the way, do not have to pay to participate in the program ("The department is supporting the program, as well as foundational support,"says Dr. Goldhagen), and they still receive their regular resident salaries.

Once arriving in their assigned countries, residents can expect to encounter a variety of health problems, "which include," says Dr. Goldhagen, "the full gambit of tropical diseases, management of malnutrition, distribution of limited resources, issues that relate to taking care of displaced persons . . ."

While some would question the wisdom in sending residents to study medicine in foreign countries when it would appear that we have enough health problems in our own backyard, Dr. Goldhagen is quick to dispel any misconceptions.

"The issue really is that many potential solutions to the problems we have in our own country can be found in the experiences and activities in developing countries," he says. "Many of the issues we're dealing with now that we're just beginning to discuss are issues with which developing countries have been dealing for years."

For example, he says, "We have significant levels of malnutrition, isolated communities with staggering rates of infant mortality, problems with access to our health system and growing limitations of resources."

These are things that have been faced by developing countries for years, he says, and residents can learn by visiting those countries, by observing how they deal with their problems. Or, as Dr. Goldhagen puts it, "The point is, *there* is where the answers to our problems *here* lay." — *Michelle J. Carlson*

Special award honors retiring chairman

A Special Award for Outstanding Service to Sports Medicine in Ohio is presented to Michael J. Vuksta, MD of Youngstown, left, outgoing chairman of the Joint Advisory Committee on Sports Medicine, by Delphis C. Richardson, MD, right, newly-appointed chairman of the Committee.

Dr. Vuksta, who served on the Committee for 20 years, and as chairman for six years, closed his practice in Youngstown to begin four years of full-time duty with the U.S. Navy as a teaching surgeon at the Navy medical facility in Oakland, California.

Photo courtesy of Robert Clinger

Auxiliary 'directs' attention on teens

Ohio teens needn't wonder anymore about who to call if they need help — whether it be physical, emotional or educational. Not, that is, if they have "Pick Up the Direct Line," a directory published by the Montgomery County Medical Society just last month.

"We were looking for a health project, so we thought, 'How can we best help the kids around here?' " says Evan Valassiades of the Montgomery County Medical Society Auxiliary's decision to publish a directory for Dayton area teens. "Help is out there, but it's finding the right help," says Valassiades, who is past president of the auxiliary, "so we decided to compile a small directory with exact agencies that help teenagers."

The result has been "Pick up the Direct Line," a small fluorescent-colored booklet filled with straight talk about the facts of life and numbers to call when teens need help. "We all have teenagers, so we know what doesn't work," says Valassiades of the auxiliary's members. "We know preaching doesn't work."

What *does* work, the auxiliary found after consulting with the county health department as well as Dayton area schools, is straight talk and information about where to get help.

"We batted about the text," Valassiades says of the directory's development. "We edited and edited and re-edited. We didn't want to put off the kids or have them laugh at it."

The auxiliary even went so far as to invite nine area principals to a meeting to discuss the directory. ("We wanted to go through the school boards," says Valassiades, "because we wanted to reach every kid.") Of those invited, she says, three came personally and several others sent representatives. Together, they went over the directory's text line by line in an effort to improve it.

The auxiliary eventually came up with a booklet that addresses a variety of topics from sexuality to the height differences between growing boys and girls. Most topics are followed by questions, that when answered, can indicate if a teen has a problem. The questions are followed by phone numbers of reputable agencies that specifically cater to teens. (Auxiliary members earlier visited dozens of agencies armed with questionnaires because, Valassiades says, "We didn't want any fly-by-night operation listed in the directory.")

The directory is aimed specifically at seventh-graders because that age "has been pinpointed as most crucial," she says. "You can still talk to them at that age."

Overall, Valassiades is very pleased with the auxiliary's effort. "The need for basic information is tremendous," she says, recalling that during a visit to a Dayton junior high school, one student revealed that she thought that if a woman cuts her hair when she's pregnant, her baby will be born bald.

"They had so many misconceptions," sighs Valassiades.

But if students have access to information — such as that contained in the directory — those misconceptions can be erased. "We're saying (with this booklet) 'Find out the facts of life . . . and don't depend on what your friend is telling you,' " she says, adding that, "We don't tell them the facts of life, we tell them where to find them."—*Michelle J. Carlson*

OSMA Auxiliary President Barbara Marshall provides a look at other community commitments made by Auxilians. *See "Auxiliary Page"*

OHIO MEDI-SCENE

Guidelines for physicians of athletic teams

These guidelines are offered by the Joint Advisory Committee on Sports Medicine of the Ohio State Medical Association, Ohio High School Athletic Association and Ohio Athletic Trainers Association. The committee hopes this material will be of benefit to the hundreds of Ohio physicians who give countless hours — for the most part as a "labor of love," with little or no financial gain — to thousands of Ohio's scholastic athletes.

I. **Qualifications**

A. The team physician must be licensed to practice in Ohio.

B. He/she may or may not serve under contract to an individual school, schools or school district.

II. **General Responsibilities**

A. The team physician should have final authority in determining the physical and mental fitness of the athletes under his charge. This authority should be clearly understood by the trainer, athletic director, all members of the coaching staffs, school officials and parents.

B. He/she should have available a complete medical history of each athlete.

C. Prior to the season (opening of practice sessions) the team physician should evaluate the health of all athletes and review examinations completed by other physicians.

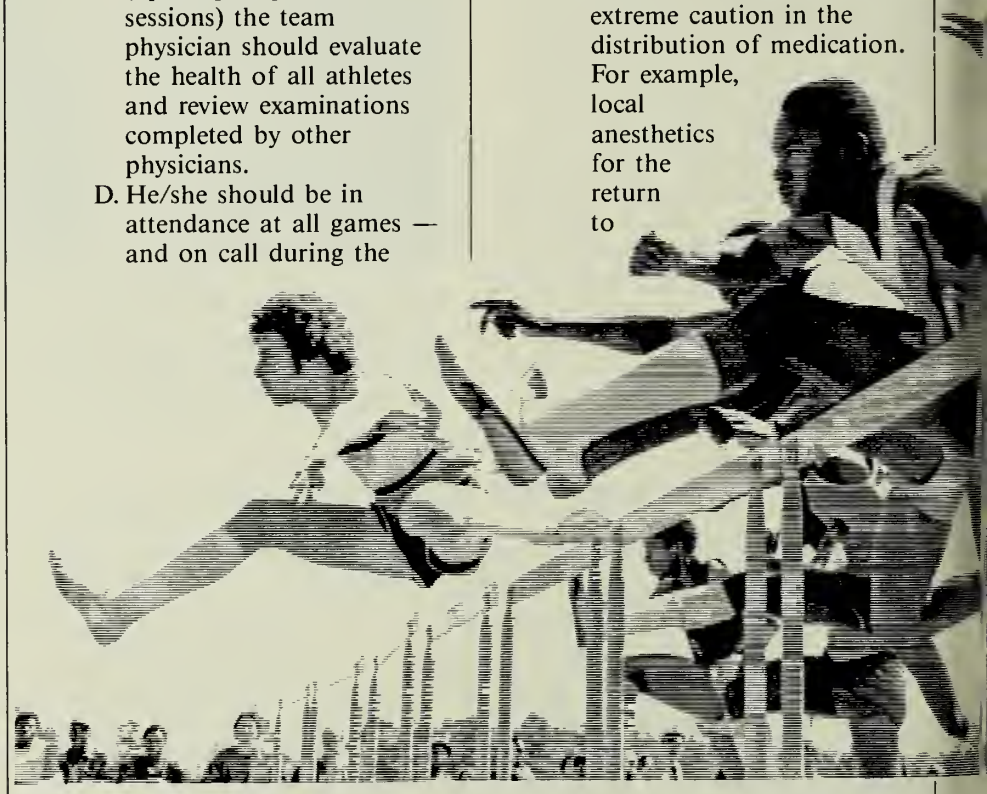
D. He/she should be in attendance at all games — and on call during the weekly practice sessions. He/she should arrange for a substitute if attendance is impossible.

E. He/she should be *the final authority* as to whether an athlete may participate — or return to competition. The team physician's medical opinion should not be altered by pressure from any source.

F. He/she should exercise extreme caution in the distribution of medication. For example, local anesthetics for the return to competition have no place in athletics.

G. He/she should ensure that only safe and reliable equipment is used in the athletic program.

H. He/she should provide or make arrangements for programs for parents and players on risks of injury, the avoidance of drugs

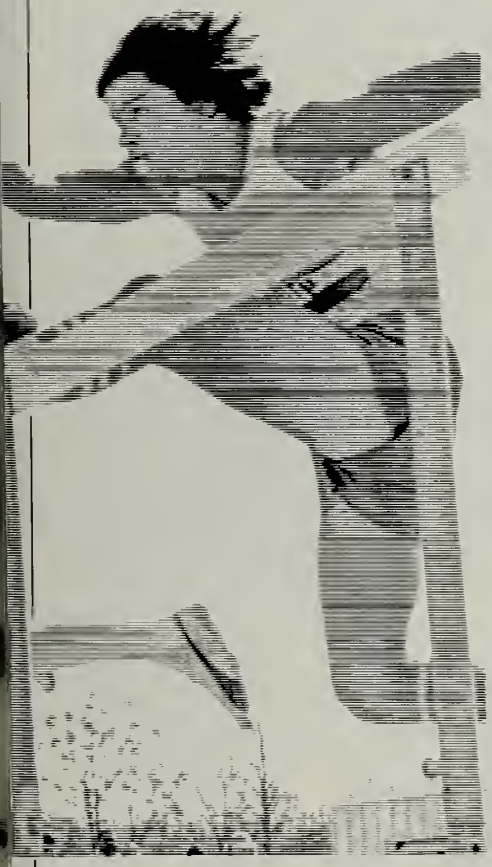


including steroids and other appropriate health and safety concerns.

III. **Relationships With the School and Community**

A. The team physician should work out written policies in the following areas with school officials and parents:

1. Ensure presence of emergency transportation and trained personnel



at the game site.
2. Ensure availability of communications (telephone) at the game site for summoning emergency transportation if it cannot be on the scene.
3. Check all aspects of legal liability (preferably with an attorney).
4. Ensure that parents understand that the team physician, while doing his/her duty, *is not a personal/family physician* — and that referrals to the athlete's personal/family physician remain at the discretion of the parents.
5. Ensure that all recommendations from the team physician be *in writing* in order to prevent misunderstanding by coaches, school officials and parents.

IV. **Relationship With the Athletic Trainer**

It would be ideal for each Ohio school competing in interscholastic athletics to have a *certified athletic trainer.* The Joint Advisory Committee on Sports Medicine wholeheartedly supports this concept. Realistically, financial limitations and the problem of placement within the faculty make this prospect highly unlikely at present for many schools.

Schools lacking a certified athletic trainer should appoint a coach or faculty member to be trained in first aid techniques. School officials and team physicians should also encourage students interested in athletic training to enroll in special workshops offered by student trainers by several Ohio colleges, universities and hospitals. Attendance by student trainers should also be encouraged at sports medicine conferences sponsored by the Joint Advisory Committee, county medical societies, Ohio Association for Health, Physical Education and Recreation, Ohio Athletic Trainers Association, and other Ohio organizations.

A. The team physician should serve as supervisor and adviser to the athletic trainer.
B. He/she should act as consultant to the trainer in therapeutic problems and allied procedures. He/she should promote with the trainer a consistent high standard of health services.
C. He/she should assist the trainer to establish and maintain a quality training room, its facilities and equipment.
D. He/she should recommend only those therapeutic techniques for which the trainer is qualified.
E. He/she should communicate with the trainer as to when an athlete may be cleared for return to competition.

V. **Field Responsibilities**

A. The team physician should arrive at the game at least 30 minutes before game time.
B. He/she should have an assigned parking space near the game site.
C. He/she should introduce himself to the officials prior to the game.
D. He/she should have the trainer check on communications equipment and availability of emergency transportation. He/she should know the location of the telephone.
E. He/she should check with the trainer for unusual medical problems among the athletes.
F. He/she should check with the visiting coach or

OHIO MEDI-SCENE

Guidelines for physicians of athletic teams . . . *continued*

athletic director to see if the team is accompanied by a physician.

G. He/she should have an area near the game site (preferably the training room) for examinations.

H. He/she should make an overview of the game site and other conditions that may cause possible medical problems. For example, the team physician should supervise the use of a sling psychrometer by the trainer if conditions of heat and humidity indicate even the most remote possibility of causing heat illness.

I. He/she should use the team area as his base (using the entire sideline if concerned about a particular injury).

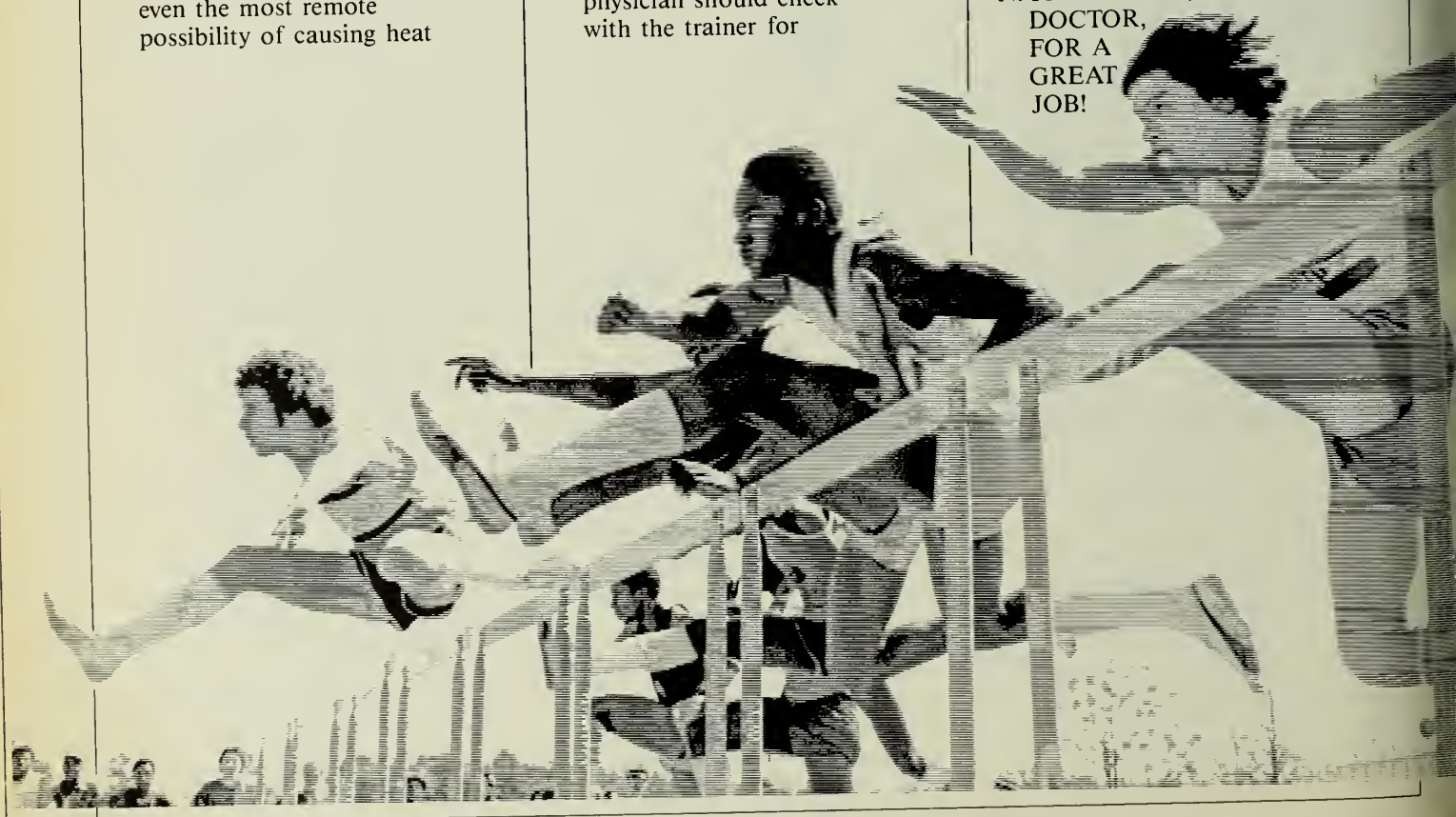
J. He/she should remain off the playing area unless summoned by an official. If there is an extreme emergency — GO!

K. He/she should closely observe the game at all times in order to detect injury-causing situations such as pileups.

L. At halftime and following the game the team physician should check with the trainer for possible injuries. If the visiting team has no physician, he/she should also check with their trainer or coach.

M. During both the season and off-season, the team physician should keep current on sports medicine developments by participating in conferences, seminars and other postgraduate programs. The Joint Advisory Committee will make every effort to publicize these sessions as far in advance as possible.

N. THANK YOU, DOCTOR, FOR A GREAT JOB!



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Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor

Warnings: *Angioedema:* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms Angioedema associated with laryngeal edema may be fatal **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone Heart failure patients given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy (See DOSAGE AND ADMINISTRATION) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology It may be advisable to eliminate the diuretic (except in heart failure patients), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments (See PRECAUTIDNS, *Drug Interactions* and ADVERSE REACTIONS) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident If excessive hypotension occurs, the patient should be placed in supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASDTEC, which usually can be given without difficulty once the blood pressure has stabilized If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered

Precautions: *General Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy In such patients, renal function should be monitored during the first few weeks of therapy

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASDTEC has been given concomitantly with a diuretic This is more likely to occur in patients with preexisting renal impairment Dosage reduction and/or discontinuation of the diuretic and/or VASDTEC may be required

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DDSAGE AND ADMINISTRATION)

Hyperkalemia Elevated serum potassium (> 5 7 mEq/L) was observed in approximately 1% ot hypertensive patients in clinical trials In most cases these were isolated values which resolved despite continued therapy Hyperkalemia was a cause of discontinuation ot therapy in 0 28% of hypertensive patients In clinical trials in heart failure, hyperkalemia was observed in 3 8% ot patients, but was not a cause for discontinuation

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASDTEC (See *Drug Interactions*)

Surgery/Anesthesia In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion

Information for Patients

Angioedema Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician

Hypotension. Patients should be cautioned to report lightheadedness especially during the first few days of therapy If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure, patients should be advised to consult with the physician

Hyperkalemia Patients should be told not to use salt substitutes containing potassium without consulting their physician

Neutropenia Patients should be told to report promptly any indication of infection (e g , sore throat, fever) which may be a sign of neutropenia

NDTE As with many other drugs, certain advice to patients being treated with enalapril is warranted This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects

Drug Interactions

Hypotension. Patients on Diuretic Therapy Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour (See WARNINGS and DOSAGE AND ADMINISTRATION)

Agents Causing Renin Release The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e g , diuretics).

Other Cardiovascular Agents VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions

Agents Increasing Serum Potassium VASDTEC attenuates potassium loss caused by thiazide-type diuretics Potassium-sparing diuretics (e g , spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium Therefore, if concomitant use of these agents is indicated because ot demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium A few cases ot lithium toxicity have been reported in patients receiving concomitant VASDTEC and lithium and were reversible upon discontinuation of both drugs Although a causal relationship has not been established, it is recommended that caution be exercised when lithium is used concomitantly with VASDTEC and serum lithium levels should be monitored frequently

Pregnancy—Category C There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day ot enalapril (333 times the maximum human dose) Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose)

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters

There are no adequate and well-controlled studies of enalapril in pregnant women However, data are available that show enalapril crosses the human placenta Because the risk of fetal toxicity with the use of ACE inhibitors has not been clearly defined, VASDTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity

Nursing Mothers Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate It is not known whether this drug is secreted in human milk Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother

Pediatric Use. Safety and effectiveness in children have not been established

Adverse Reactions: VASDTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more VASDTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients

HYPERTENSIDN The most frequent clinical adverse experiences in controlled trials were headache (5 2%), dizziness (4 3%), and fatigue (3%)

Other adverse experiences occurring in greater than 1% of patients treated with VASDTEC in controlled clinical trials were diarrhea (1 4%), nausea (1 4%), rash (1 4%), cough (1 3%), orthostatic effects (1 2%), and asthenia (1 1%)

HEART FAILURE The most frequent clinical adverse experiences in both controlled and uncontrolled trials were dizziness (79%), hypotension (6 7%), orthostatic effects (2 2%), syncope (2 2%), cough (2 2%), chest pain (2 1%), and diarrhea (2 1%).

Dther adverse experiences occurring in greater than 1% ol patients treated with VASOTEC in both controlled and uncontrolled clinical trials were fatigue (1 8%), headache (1 8%), abdominal pain (1 6%), asthenia (1 6%), orthostatic hypotension (1 6%), vertigo (1 6%), angina pectoris (1 5%), nausea (1 3%), vomiting (1 3%), bronchitis (1 3%), dyspnea (1.3%), urinary tract infection (1 3%), rash (1 3%), and myocardial infarction (1 2%).

Dther serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0 5% to 1% ot patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category

Cardiovascular Cardiac arrest, myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*), cardiac arrest, pulmonary embolism and infarction, rhythm disturbances, atrial fibrillation, palpitation

Digestive Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis

Nervous/Psychiatric. Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia

Urogenital Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATIDN)

Respiratory Bronchospasm, rhinorrhea, asthma, upper respiratory infection

Skin Herpes zoster, pruritus, alopecia, flushing, photosensitivity

Dther Vasculitis, muscle cramps, hyperhidrosis, impotence, blurred vision, taste alteration, tinnitus

A symptom complex has been reported which may include fever, myalgia, and arthralgia, an elevated erythrocyte sedimentation rate may be present Rash or other dermatologic manifestations may occur. These symptoms have disappeared after discontinuation of therapy

Angioedema Angioedema has been reported in patients receiving VASOTEC (0 2%) Angioedema associated with laryngeal edema may be fatal If angioedema ot the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately (See WARNINGS)

Hypotension. In the hypertensive patients, hypotension occurred in 0 9% and syncope occurred in 0 5% ot patients following the initial dose or during extended therapy Hypotension or syncope was a cause for discontinuation ot therapy in 0 1% of hypertensive patients In heart failure patients, hypotension occurred in 6 7% and syncope occurred in 2 2% ot patients Hypotension or syncope was a cause for discontinuation of therapy in 1 9% of patients with heart failure (See WARNINGS)

Clinical Laboratory Test Findings

Serum Electrolytes Hyperkalemia (see PRECAUTIDNS), hyponatremia

Creatinine, Blood Urea Nitrogen In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation ot therapy, were observed in about 0 2% of patients with essential hypertension treated with VASDTEC alone Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis (See PRECAUTIDNS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation ot VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1 2% of patients

Hemoglobin and Hematocrit. Small decreases in hemoglobin and hematocrit (mean decreases ot approximately 0.3 g % and 1 0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASDTEC but are rarely of clinical importance unless another cause of anemia coexists In clinical trials, less than 0 1% ot patients discontinued therapy due to anemia

Other (Causal Relationship Unknown). In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported

Liver Function Tests Elevations of liver enzymes and/or serum bilirubin have occurred

Dosage and Administration: *Hypertension.* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose ot VASDTEC The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASDTEC to reduce the likelihood ot hypotension (See WARNINGS) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed

If the diuretic cannot be discontinued, an initial dose of 2 5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour (See WARNINGS and PRECAUTIDNS, *Drug Interactions*)

The recommended initial dose in patients not on diuretics is 5 mg once a day Dosage should be adjusted according to blood pressure response The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASDTEC alone, a diuretic may be added

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS)

Dosage Adjustment in Hypertensive Patients with Renal Impairment The usual dose ol enalapril is recommended for patients with a creatinine clearance >30 mL/min (serum creatinine of up to approximately 3 mg/dL) For patients with creatinine clearance ≤30 mL/min (serum creatinine ≥3 mg/dL), the first dose is 2 5 mg once daily The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily

Heart Failure VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2 5 mg once or twice daily After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour (See WARNINGS and PRECAUTIDNS, *Drug Interactions*) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension The appearance of hypotension after the initial dose of VASDTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses The maximum daily dose is 40 mg Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2 5 to 40 mg per day of VASDTEC, almost always administered in two divided doses. (See CLINICAL PHARMACDLDGY, *Pharmacodynamics and Clinical Effects.*) Dosage may be adjusted depending upon clinical or hemodynamic response (See WARNINGS)

Dosage Adjustment in Heart Failure Patients with Renal Impairment or Hyponatremia In heart failure patients with hyponatremia (serum sodium <130 mEq/L) or with serum creatinine >1 6 mg/dL, therapy should be initiated at 2 5 mg daily under close medical supervision (See DOSAGE AND ADMINISTRATION, *Heart Failure*, WARNINGS, and PRECAUTIDNS, *Drug Interactions*) The dose may be increased to 2.5 mg b i d., then 5 mg b i d and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function The maximum daily dose is 40 mg

For more detailed information, consult your MSD Representative or see Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486. J6VS18R2(817)

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Sometimes, even adults preserve the myth . . .

The Superman Pajamas Syndrome

By Carl A. Culley, Jr., MD

When my son was three years old, he received a pair of Superman pajamas as a present. After trying them on and running back and forth across the room several times, he walked up to me and asked dejectedly, "How do you get these things to fly?"

I've noticed that children are not alone in believing that if you dress something in a different package, you create a new entity. For instance, some people think that if medical problems somehow assume the properties of a business, patients will decide to get sick only when it fits into this year's budget.

It occurs to me that this type of thinking is abnormal enough to qualify as a disease in its own right. With that in mind, I would like to describe the "Superman Pajamas Syndrome."

"I've noticed that children are not alone in believing that if you dress something in a different package, you create a new entity."

I'm afraid that there is no shortage of examples of this new syndrome in the medical field. I will present some typical expressions that illustrate symptoms, so that practitioners can be alert to the diagnosis. We know what the following terms are supposed to mean, so each will be followed by its new definition:

- **Client:** a patient who voluntarily gets sick.
- **Contingency:** contingent upon whether the lawyer thinks he can win the case — if not, see "fee for service."
- **Customary:** what doctors charged before antitrust laws were enforced.
- **Deposition:** process by which lawyers deposit a certain material on defendant physician.
- **Explanation of Medicare Benefits:** a form that confuses people so much that they just give up and pay the fee themselves.
- **Group Insurance:** a type of insurance that combines your risk of disease with that of a lot of other people whom you ordinarly would not know and whom you definitely cannot control.
- **Health Maintenance Organization:** a group of people who try to maintain their health because they cannot get medical services when they are sick.
- **Indemnity Insurance:** insurance that keeps you "unharmed" by harming you in advance with huge premiums.
- **Individual Nursing Care Plan:** pre-printed sheets that can be filed on a patient's chart.
- **Jury of Peers:** 12 people who know nothing about medicine.
- **Preferred Provider Organization:** a group of people who agree to see the doctor who their insurance company prefers.
- **Provider:** someone who is willing to work for what other people feel like paying him.
- **Quality Assurance:** assuring the quality of something by looking at it retrospectively.
- **Reasonable:** within this year's compromise budget.
- **Usual:** what doctors usually charged several years ago.
- **Wrongful Death:** the opposite of wrongful life.

I'm certain that as this syndrome becomes more widely recognized, readers will be able to provide other case reports to enrich the literature. Unfortunately, no known treatment exists. **OSMA**

Carl A. Culley, Jr., MD, Cleveland, is a member of the **Cleveland Physician***'s editorial board. This article first appeared in the* **Cleveland Physician,** *the monthly publication of the Academy of Medicine of Cleveland.*

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AMA Forms Department for Foreign Medical Graduates

By John Kasper

Editor's Note: *In February 1989 the American Medical Association created a new department — the Department of Foreign Medical Graduates. John E. Kasper, CAE, formerly a field representative for the AMA, was appointed as director of this new department. Casper was in Ohio in July to address a meeting of Ohio's county medical society executives. Below is the text of his remarks.*

Introduction

The American Medical Association (AMA) formed a new division-level operating unit in February of 1989, namely the Office of Special Groups. There are four departments within this office:

(1) Department of Women in Medicine;
(2) Department of Employed and Large Group Practice Physicians;
(3) Department of Private Sector Outreach; and
(4) Department of Foreign Medical Graduates (FMGs).

This article deals with the last department mentioned, namely the Department of FMGs. Effective June 1, 1989, I was appointed as its director. Formerly, I was a field representative in the AMA Department of State and County Relations. In that capacity, I was assigned Ohio as one of the 15 states for which I had responsibility. For the seven and a half year period prior to my hire by the AMA in September 1986, I directed the state and federal legislative programs and managed the labor relations issues for a nursing specialty organization.

Departmental Responsibilities

My position charter charges me with the following responsibilities in regard to FMGs:

(1) developing and implementing a variety of communication and liaison mechanisms with FMGs across the country;
(2) with the advice of those FMGs, addressing the identified concerns;
(3) communicating AMA programs and policies to FMGs;
(4) providing consultative and liaison services to members of the Federation of Medicine (state, county and specialty organizations) to expand the infrastructure for FMGs; and
(5) developing and maintaining close liaison ties with the officers and staff of national groups representing FMGs.

What does that really mean?

As I view my position, it really comes down to me being responsive to four individual groups:

(1) individual FMGs;
(2) groups representing FMGs;
(3) state, county and specialty medical associations; and
(4) internal AMA operating units.

Departmental Activities

What have I been doing for the first two months on the job as the director of this new department?

In regard to individual FMGs, I have spoken to a significant number over the telephone on various issues. The issues that appear to continue to arise in regard to this constituency are:

(1) licensure/reciprocity issues;
(2) issues dealing with perceived

discrimination in FMG residency applications;
(3) issues arising from perceived discrimination against FMGs in regard to employment decisions as well as hospital staff privilege determinations;
(4) visa problems; and
(5) individual concern/disagreement with AMA policies and/or programs.

In regard to groups representing FMGs, to date I have contacted 15 major ethnic organizations identified in available resource material. In those contacts, I have relayed pertinent AMA Annual Meeting activities as well as requested input into programs that this department might develop. Further contacts will occur in the future on an ongoing basis.

I have also personally met with two groups representing FMGs, and plan to meet individually with more groups as time progresses.

In regard to state and county medical associations, I have sent out an AMA/Mail survey to all state and county medical associations with mailboxes on the system. In that survey I requested the following specific information:
(1) relevant activities relating to FMGs;
(2) an identification of specific staff dealing with these issues; and
(3) an identification of FMGs who are active in the societies.

I am hopeful that the survey will be the first of many mechanisms with which I can obtain advice from the federation in regard to activities that my department might undertake. I am very interested in working with the federation to develop programs that its constituents want to see and that would be helpful. I am not interested in creating programs in a vacuum.

Finally, in regard to internal AMA operating units, I have met with various individuals throughout the association, attempting to determine what has been done as well as determining how to best coordinate staff activities regarding FMGs in the future.

Demographics

Demographically, I have been attempting to build a solid database for states and counties to use in regard to FMGs. As of year-end 1988, there were 128,609 FMGs in the country. That population consisted of 109,251 foreign-born FMGs and 19,358 U.S. FMGs. Of the total population, 41,803 were AMA members for a market share of 32.5%.

Both the rate of increase of FMGs in this country and the rate of increase of AMA members of this constituency have continued to decline in the eight-year period from 1980-88.

Ohio is the eighth largest state in the country in regard to the total number of FMGs, with 5,795 FMG physicians reported in the state as of year-end 1988. County membership in terms of the percentage of the total number of physicians in each county ranges from a low of 11.9% to a high of 59.7%.

In the state as a whole, 25.1% of all the physicians are FMGs, with the AMA market share among that group at 38.2%.

Future Activities

What would I like to see happen in this area in the next year?

To begin, I would like to continue and strengthen the good working relationships that I have developed with state and county medical associations in terms of the activities that seem particularly effective in mainstreaming FMGs into organized medicine.

I would like to continue to develop solid statistics regarding this constituency and share them with the federation and other interested groups/individuals.

I will continue to meet with FMG leadership to discuss the relevant issues of importance.

I would like to see the AMA as well as the constituents in the federation become more advocative in our role with FMGs in this country. AMA policy is firmly established in opposition to discrimination against FMGs based solely on the country in which they receive their medical education. This policy needs to be disseminated in an effective manner. I believe with the adoption of a more advocative role on the part of the national association as well as the state and county medical organizations, we will see an increase in the interest of FMGs to participate in organized medicine.

Conclusion

I welcome comments in regard to possible AMA/federation programs for graduates of foreign medical schools. My telephone number at the AMA is (312) 645-5624. I look forward to speaking with you on these matters.

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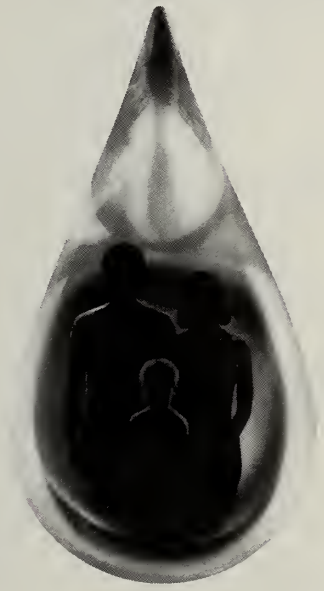

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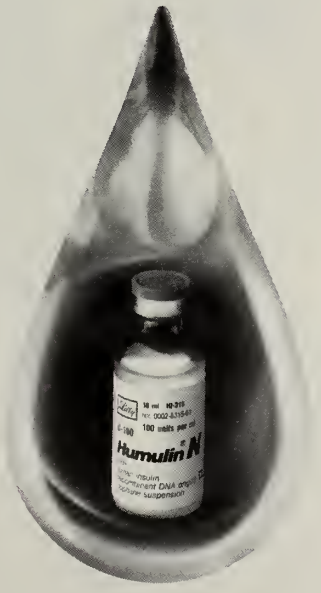

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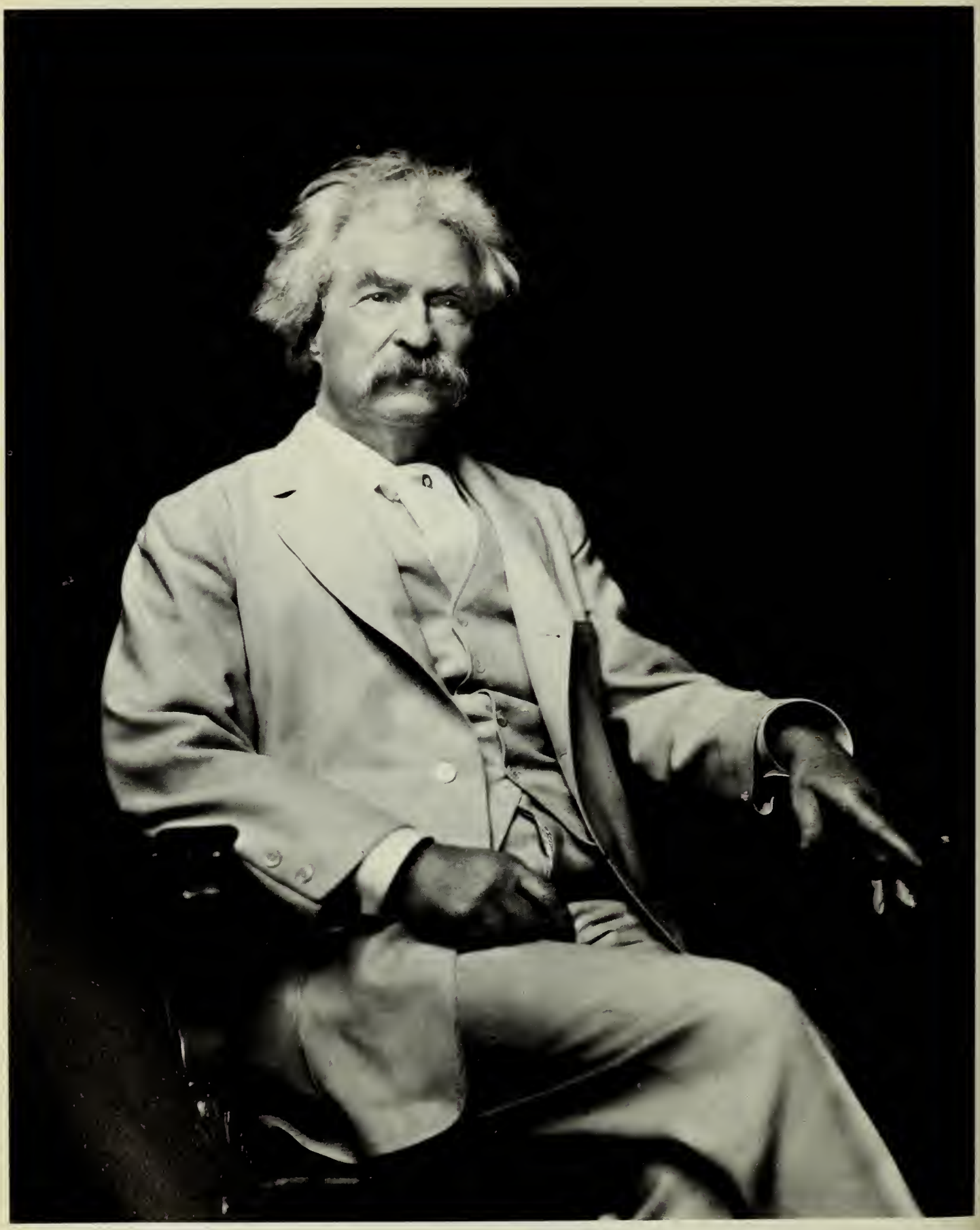


Mark Twain in Ohio

The Novelist's Visits With Some of His Medical Opinions

By James G. Ravin, MD

Mark Twain had a long, intimate relationship with Ohio, visiting our state many times. Ohioans liked Twain and enjoyed what he had to say on his several lecture tours. Twain lived in Cincinnati as a young man, and later nearly decided to base his life in Cleveland. He had many humorous tales to tell on medical topics. Most of this information is largely unknown and it merits further dissemination.

Cincinnati

Twain's least known episode in Ohio was his Cincinnati period of 1856 and 1857. He came to the Queen City at age 20 from Keokuk, Iowa, where he had been in the printing business with his brother, Orion. He was still known as Samuel Clemens at the time. There is relatively little documentation of his six-month stay in Cincinnati. In his autobiography he told a tale of finding a lost $50 bill and advertising the fact in the Iowa newspapers. Several days later, no longer able to endure waiting for its owner to claim it, he said, "I felt I must take that money out of danger. So I bought a ticket for Cincinnati and went to that city. I worked there several months in the printing office of Wrightson and Company."[1] He worked hard for Cincinnati's largest printer, 10 hours a day, six days a week, earning $12 a week, but he left us very little information about that period of time. William Baker, a retired professor of English at Wright State University, has done extensive research concerning Twain's period in Cincinnati and has concluded that Twain found only "the oppressive grind of hard work with no hope of a future in Cincinnati."[2]

The six months in Cincinnati gave him some good experience. In "The Turning Point of My Life" he wrote that being a printer gave one the opportunity of "setting up acres of good and bad literature, and learning — unconsciously at first, consciously later — to discriminate between the two, within his mental limitations; and meanwhile he is consciously acquiring what is called style."[3] Twain wrote some fiction under a pseudonym while in Cincinnati, but none of this mentions the city by name. He learned the difficulties of writing and spent a winter in Ohio.

Leaving Ohio behind in 1857, he ventured down the Mississippi River. He had dreamt of traveling to South America to harvest coca leaves. An Iowa physician briefly shared his pipe dream with him, but neither man pursued this fancy. Twain then became a Mississippi river boat pilot. The pilot's guide was published by Twain's Cincinnati employer, and he may have memorized much of its contents while in Cincinnati.

When the hostilities of the Civil War interrupted river traffic, Twain turned westward and spent several years in Nevada and California. There he developed a regional reputation as a writer and lecturer. He began to earn a national

"Sitting lazily at the table, scarcely genteel in his appearance, there is something, I know not what, that interests and attracts . . ."

reputation with his short story, "The Celebrated Jumping Frog of Calaveras County."

Cleveland Friends

In 1867 a new opportunity arose. Newspapers in San Francisco and New York sent him to Europe and the Middle East as a correspondent. The 31-year-old writer had his passage paid ($1,250, an enormous sum at that time), was given gold for expenses and the opportunity to be paid $20 per letter received for publication. The letters he wrote on this trip were later collected and published in book form as "The Innocents Abroad" (1869).

At the time, Twain was a rough Westerner who smoked 40 or more cigars a day, spoke with much profanity and looked quite unique in dress and hairstyle. He traveled via ship with a group of sophisticated, wealthy Easterners who were making a pilgrimage to Europe and the Holy Land that was the idea of the Rev. Henry Ward Beecher. A number of the passengers were from Cleveland, and several became his lifelong friends and confidants. Although a trip of this sort is common today, it was rare to travel this distance, and it allowed Twain to write one of the most famous travel books of all time. He met Mary M. Fairbanks, whose husband published the Cleveland *Herald.* She was writing a travelogue for that newspaper. Mrs. Fairbanks was an educated and cultured woman who endeavored to polish both the manners and prose of Twain, who she recognized as a diamond in the rough. For years afterward Twain regularly sent her hundreds of pages of manuscript to review before publication. Also on board ship was another Cleveland couple who befriended Twain and aided him, Mr. and Mrs. Solon Severance.

Mark Twain's merit as an author is not decreased by understanding the help he received from these mentors. Their guidance was cleverly described in the Cleveland *Plain Dealer:* "He was yet awkward of manner and style. He who steered Mississippi River boats required a personal pilot. He who had been a printer's devil was yet in the uncorrected proof state. He would had prospect, for gold in the West was just beginning to strike literary pay dirt."[4] His tendency toward profanity was out of keeping with a visit to the Holy Land. His mentors did not break him of his former habits, but succeeded in restraining him. Later his wife was able to make further "progress." Twain's oldest daughter wrote, "Papa uses very strong language, but I have an idea not nearly so strong as when he first married mamma (sic)."[5]

Twain wrote of Mrs. Fairbanks, who he affectionately called "Mother": "She was the most refined, intelligent and cultivated lady on the ship, and altogether the kindest and best. She sewed my buttons on, kept my clothes in presentable trim, fed me on Egyptian jam (when I behaved), lectured me awfully on the quarterdeck . . . and cured me of several bad habits."[6]

Mrs. Fairbanks in turn wrote: "We have D.D.'s and M.D.'s — we have men of wisdom and men of wit. There is one table from which there is sure to come a peal of laughter, and all eyes are turned toward Mark Twain, whose face is perfectly mirth provoking. Sitting lazily at the table, scarcely genteel in his appearance, there is something, I know not what, that interests and attracts. I saw today at dinner venerable divines and sage-looking men convulsed in laughter at his drolleries and quaint, odd manners."[7]

First Ohio Lecture Tour, 1868-69

The following year Twain embarked on a lecture tour of Ohio that included talks in Cleveland, Akron, Toledo, Norwalk, Ravenna and Alliance. The first talk was given in Cleveland on November 17, 1868, at the invitation of the two ladies from Cleveland who had befriended him. He acknowledged their assistance in a letter to Mrs. Severance saying "I shall always remember both of you gratefully for the training you gave me —

you in your mild, persuasive way, and she in her efficient, tyrannical, overbearing fashion."[8]

Twain was 33 years of age when he came for this Ohio tour. His talk began as a series of anecdotes about the visit to Europe and the Middle East, and soon evolved into a promotion for his new book, "The Innocents Abroad." The tour was a success for several reasons. First, he was friendly with the editors of the Cleveland *Herald* and the Toledo *Blade*. Each paper gave him copious, enthusiastic coverage which served as advance promotion for his talks. Second, Twain spoke and wrote in a down-to-earth manner to which Ohioans could relate. Ohioans could identify with Twain, who was "roving, independent, free and easy . . . not elaborately educated, cultivated and refined."[9]

The Toledo *Blade* commented: "Twain is witty, and his wit comes from his own fertile brain. His style is original, and his manner of speaking is not after the manner of men generally. His serious face and long drawn words are, of themselves, sufficient to make one laugh, even if there were not in every sentence a sparkling gem of humor, an original idea. His anecdotes, with which the lecture is replete, are rich, and, as he tells them, irresistibly funny."[10]

The Cleveland *Plain Dealer* reported that his "slightly incoherent address of between one and two hours duration — mingling the most irresistible humor with little flights of eloquence, and making up an entertainment of which it was impossible to tire. Mr. Clemens' manner very much enhanced the effect of his remarks — there is a dry, comical drawl in his voice that is irresistible in a funny story."[11] The Cleveland *Herald* stated, "We expected to be amused, but we were taken by surprise when he carried us on the wings of his redundant fancy, away to the ruins, the cathedrals and the monuments of the old world . . . word painting which haunts us like a remembered picture. He proved a man can be humorous without being a clown."[12]

The Norwalk *Reflector* praised his lecture, saying "its humorous points convulsed the audience with frequent laughter — while its occasional burst of eloquence showed the author to be a prolific writer."[13] A Ravenna newspaper said, "It would have been impossible to believe that so much fun could have been compressed into an hour."[14]

An important part of his 1868-69 visit to Ohio was Twain's attempt to become a part owner of a newspaper. He was offered positions on the Cleveland *Herald* and the Toledo *Blade*. Since he had formed a close relationship with an owner of the Cleveland newspaper, and since he felt this would be a good base of operations, he negotiated earnestly with its owners. However, the negotiations failed. Twain accepted an offer from a Buffalo newspaper and moved there. Twain wrote several letters to his fiancée during this Ohio period, which reveal his strong desire to stay in Cleveland.

Second Ohio Tour, 1871-72

Twain, now 36 years of age, returned to Ohio and lectured in six cities: Toledo, Dayton, Columbus, Wooster, Salem and Steubenville. This was part of a lecture tour of the eastern United States and served to publicize his new book, "Roughing It" (1872), tales of adventure and humor in the West and the Pacific.

Reviews in Ohio newspapers were nearly all favorable. The Cincinnati *Commercial* said, "Judging from the frequent bursts of applause and laughter, we should say the efforts of the lecturer to entertain and amuse his listeners were highly successful."[15] The Dayton *Journal* said, "His fame as a versatile and humorous writer is more widely spread, perhaps, than any other man in his line . . . hearty laughter and frequent applause were, after all, the best criticism upon the entertainment."[16]

Third Ohio Tour, 1884-85

Since his last visit to Ohio, Twain had published "The Adventures of Tom Sawyer," (1876), "The Prince and the Pauper" (1881), and "Life on the Mississippi" (1883). The third tour was designed to be part of a publicity campaign to promote his latest book, "The Adventures of Huckleberry Finn," (1884). Twain spoke in Toledo, Dayton, Hamilton, Cincinnati, Columbus, Delaware and Oberlin. The 49-year-old author was received enthusiastically by the papers everywhere except for the college town of Oberlin, which found his talk a bit juvenile. The Oberlin *Review* said, "Although some, to whom Twain's humor is distasteful, were disappointed, the greater part of the audience, especially the younger part, enjoyed the entertainment thoroughly."[17]

The Toledo *Blade* enjoyed his "droll humor, delivered in the funniest manner" and said that "Mark Twain is a prime funny man, and he is just as funny on the stage, in words, tones, gestures and attitudes, as he is in his books."[18] The Cincinnati *Enquirer* reported that Twain is "tall, awkward, gestureless, with a shock head of iron-gray hair and a deeply furrowed tired face. With all these rostrum disadvantages, he

enters upon the stage, nevertheless, with the self-possessed ease of a man passing into his own drawing room. The look upon his features suggests that he has mislaid his eyeglasses and returned to look for them. Finding a number of persons present, he stops and has a long talk with them, during which they are the most willing listeners in the world."[19]

Fourth Ohio Tour, 1895

In 1895 the 60-year-old Twain spoke in only one Ohio city, Cleveland. His last lecture in Ohio was the first stop on a worldwide tour designed to help him recover from financial losses he had suffered from poor investments. The Cleveland *Plain Dealer* related his sketches, including a humorous one on morals. The paper reported:

> "It was his idea that the commission of a crime should leave its imprint upon the conscience of a man and he would never commit that crime again. When he had committed all the crimes on the calendar, and there were 462 of them, he would be a moral man. His first pangs of conscience were when he took a green watermelon from a farmer's wagon. He made restitution and taught the farmer a lesson so that he gave him another melon, and a ripe one at that."[20]

On Physicians and Medicine

Surprisingly, knowing Twain's reputation for cynicism, he had kind words for doctors, saying, "The physician is the highest and worthiest of all occupations, or would be if human nature did not make superstitions and priests necessary."[21] He tempered this by saying, "A half-educated physician is not valuable. He thinks he can cure everything."[22] Twain had this warning for the prospective surgical patient who is to undergo surgery: "Console yourself with the reflection that you are giving the doctor pleasure, and that he is getting paid for it."[23] He was well aware of the power of humor and a good outlook on life as a weapon against illness. He liked to say that humanity, "in its poverty, has unquestionably one really effective weapon — laughter . . . Against the assault of laughter, nothing can stand."[24] Another time he said, "Such a laugh was money in a man's pocket, because it cut down the doctor's bill like everything."[25]

He liked to say he lacked knowledge of art and of surgery, "Because people who understand art find nothing in pictures but blemishes, and surgeons and anatomists see no beautiful women in all their lives, but only a ghastly stack of bones with Latin names to them, and a network of nerves and muscles and tissues."[26] Twain contrasted his lack of knowledge of medicine with his knowledge of writing. Humorously, he would say that one might ask an author for a sample of his work, but advised not to ask a physician for a sample since, "It would never be fair to ask a doctor for one of his corpses to remember him by."[27] Occasionally physicians would be the target of his humor. He pointed a joking finger at a doctor who had been in practice for a year and had only two or three patients. Twain recalled that he had attended all of their funerals. Often he would receive letters from admirers suggesting remedies for his various ailments. Twain would reply, "I try every remedy sent to me. I am now on No. 67. Yours is 2,653. I am looking forward to its beneficial results."[28] In a similar vein, he liked to tell the tale of ships that had no physician on board, just a medicine chest with the drugs numbered instead of named, accompanied by a book of directions. When one medication was used up, the captain would switch to another and notice how quickly the demise of the sick sailor followed.[29] He also liked to poke fun at the medications of his youth: "Galen could have come into my sick room at any time during my first seven years — I mean any day when it wasn't fishing weather, and there wasn't any choice but school or sickness — and he could have sat down there and stood my doctor's watch without asking a question. He would have smelt around among the wilderness of cups and bottles and vials on the table and shelves, and missed not a stench that used to glad him 2,000 years before, nor discover one that was of a later date."[30]

In discussing his own illnesses, he liked to retell the story of his visit to the baths at Aix, France, and what the baths could do. "I had come here as innocent of disease as a grindstone, and inside of three weeks these baths sluiced out of me every important ailment known to medical science, along with considerable more that were entirely new and patentable."[31] He liked to say he lacked the willpower to discontinue his favorite habits which included smoking, coffee, tea and whiskey. He advised others not to try his habits as a means of achieving old age since they assisted him, but would assassinate others.[32]

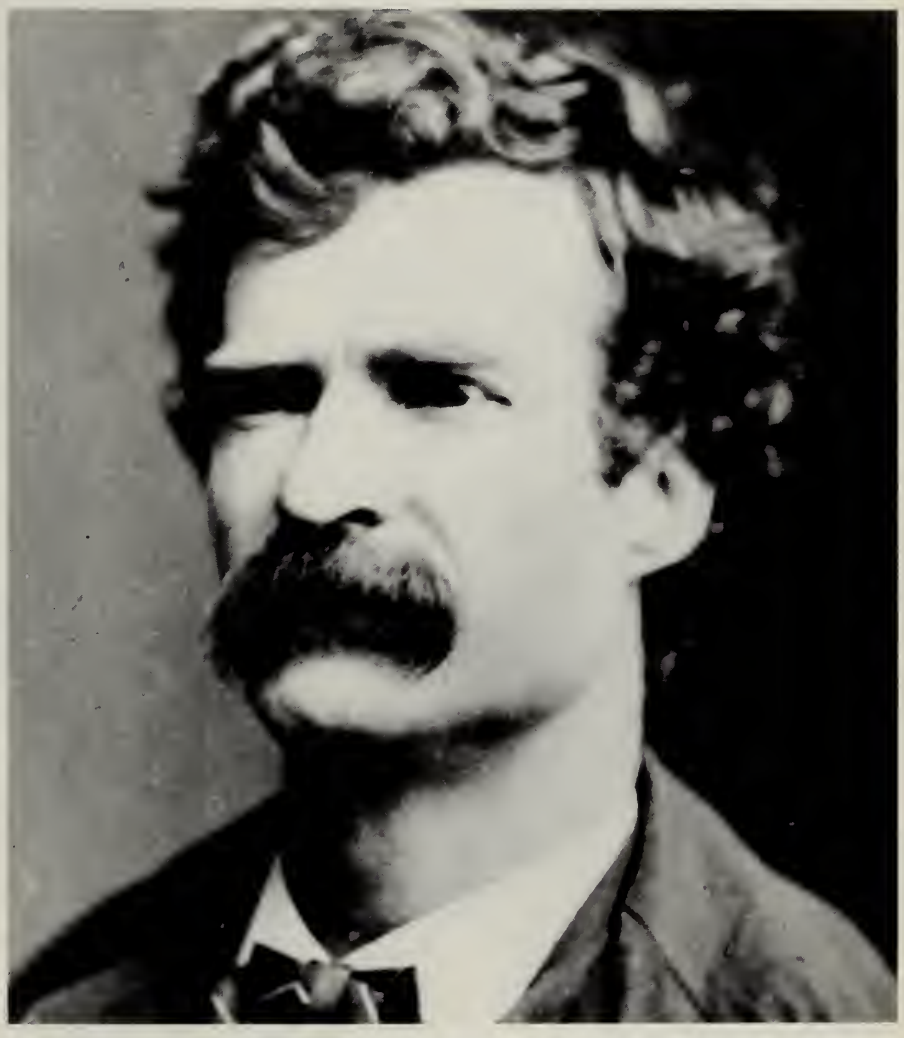
Recommendations for Health

The only way to keep your health, wrote Twain, is "to eat what you don't want, drink what you don't like, and do what you druther not."[33] To women, he said, "Don't smoke, that is, don't

smoke to excess. I am 73½ years old and I have been smoking 73 of them. But I never smoke to excess — that is, I smoke in moderation, only one cigar at a time."[34] He also told the girls not to drink to excess nor to marry to excess. When warned that his smoking would shorten his life by 10 years he told his advisers they were wasting their time with that advice, for "they little knew how trivial and valueless I would regard a decade that had no smoking in it!"[35]

It seems a shame that Twain did not become a permanent resident of the Buckeye State. Who knows what would have resulted — "Life on the Ohio"? **OSMA**

James G. Ravin, MD, Toledo, is an ophthalmologist and chairman of the OSMA's Art and Culture Committee.



Vintage Mark . . . Twain in his earlier days.

References

1. Twain M: "Mark Twain's Autobiography." NY, Harper, 1924; II: 289.
2. Baker W: Mark Twain in Cincinnati: A Mystery Most Compelling. *American Literary Realism.* 1979; 12(2):300.
3. Twain, in Baker. p. 308.
4. Bacon RM and Bacon MV: Unpublished Letters of Mark Twain Discovered Here. Cleveland *Plain Dealer* magazine. November 17, 1935, p. 1.
5. Clemens S, in Bacon and Bacon, p. 1.
6. Wecter D ed.: "Mark Twain to Mrs. Fairbanks." San Marino: Huntington Library, 1949, p. xxii.
7. Wecter, p. xxi.
8. Wecter, p. 110.
9. Twain, in Baker, p. 17.
10. Toledo *Blade,* January 21, 1869.
11. Cleveland *Plain Dealer.* November 18, 1868; in Bacon RM and Bacon MV: Twain's First Cleveland Lecture. Cleveland *Plain Dealer.* November 22, 1935.
12. Cleveland *Herald.* November 18, 1808, in Bacon and Bacon, November 22, 1935.
13. Norwalk *Reflector.* January 22, 1869, in Baker, p. 19.
14. Baker, p. 20.
15. Cincinnati *Commercial.* December 11, 1871, in Baker, p. 20.
16. Dayton *Journal.* January 5, 1872, in Baker, p. 21.
17. Oberlin *Review.* February 21, 1872, in Baker, p. 24.
18. Toledo *Blade.* December 16, 1884, p. 1.
19. Cincinnati *Enquirer.* January 3, 1885, p. 4.
20. Cleveland *Plain Dealer.* July 16, 1895, in Bacon RM and Bacon, MV: Mark Twain's Last Lecture in Cleveland. Cleveland *Plain Dealer.* November 23, 1935.
21. Twain, M: "Mark Twain's Notebook." NY, Harper, 1935, p. 166. References 21-35 are indexed in Harnsberger, CL: "Mark Twain at Your Fingertips." NY, Beechurst, 1948.
22. Twain, "Notebook," p. 219.
23. Henderson A: "Mark Twain." NY, Stokes, 1912, p. 115.
24. Twain M: "The Mysterious Stranger." NY, Harper, 1922, p. 132.
25. Twain, M: "The Adventures of Tom Sawyer." NY, Harper, 1899, p. 268.
26. Walker F and Dane GE, eds: "Mark Twain's Travels with Mr. Brown." NY, Knopf, 1940, p. 238.
27. Bok E: "The Americanization of Edward Bok." NY, Scribner, 1912, p. 204.
28. Clemens C: "My Father — Mark Twain." NY, Harper, 1931, p. 287.
29. Twain M: "Tom Sawyer Abroad." NY, Harper, 1899, p. 270.
30. Twain M: "The American Claimant." NY, Harper, 1899, p. 525.
31. Twain M: "Europe and Elsewhere." NY, Harper, 1923, p. 108.
32. Paine AB, ed: "Mark Twain's Speeches." NY, Harper, 1923, p. 431.
33. Twain M: "Following the Equator." NY, Harper, 1897, p. 151.
34. Twain, "Speeches." p. 107.
35. Paine AB, ed.: "Mark Twain's Letters." NY, Harper, 1917, I: 180.

Alzheimer's Disease: Are We Making Any Progress?

By Karen S. Edwards

Eighty-three years after German neuropsychiatrist Alois Alzheimer first described the condition that bears his name, medicine is still attempting to discover a cause, a treatment, a cure for this debilitating illness.

Today, approximately 1.5 to 3 million Americans have been diagnosed with Alzheimer's disease — including 105,000 patients here in Ohio — and many more undiagnosed cases may yet exist.

Is medicine making *any* progress at all against this formidable adversary?

The answer is yes, but like the course of the disease itself, progress is painstakingly slow.

The nature of the beast

So, what *have* we learned about Alzheimer's?

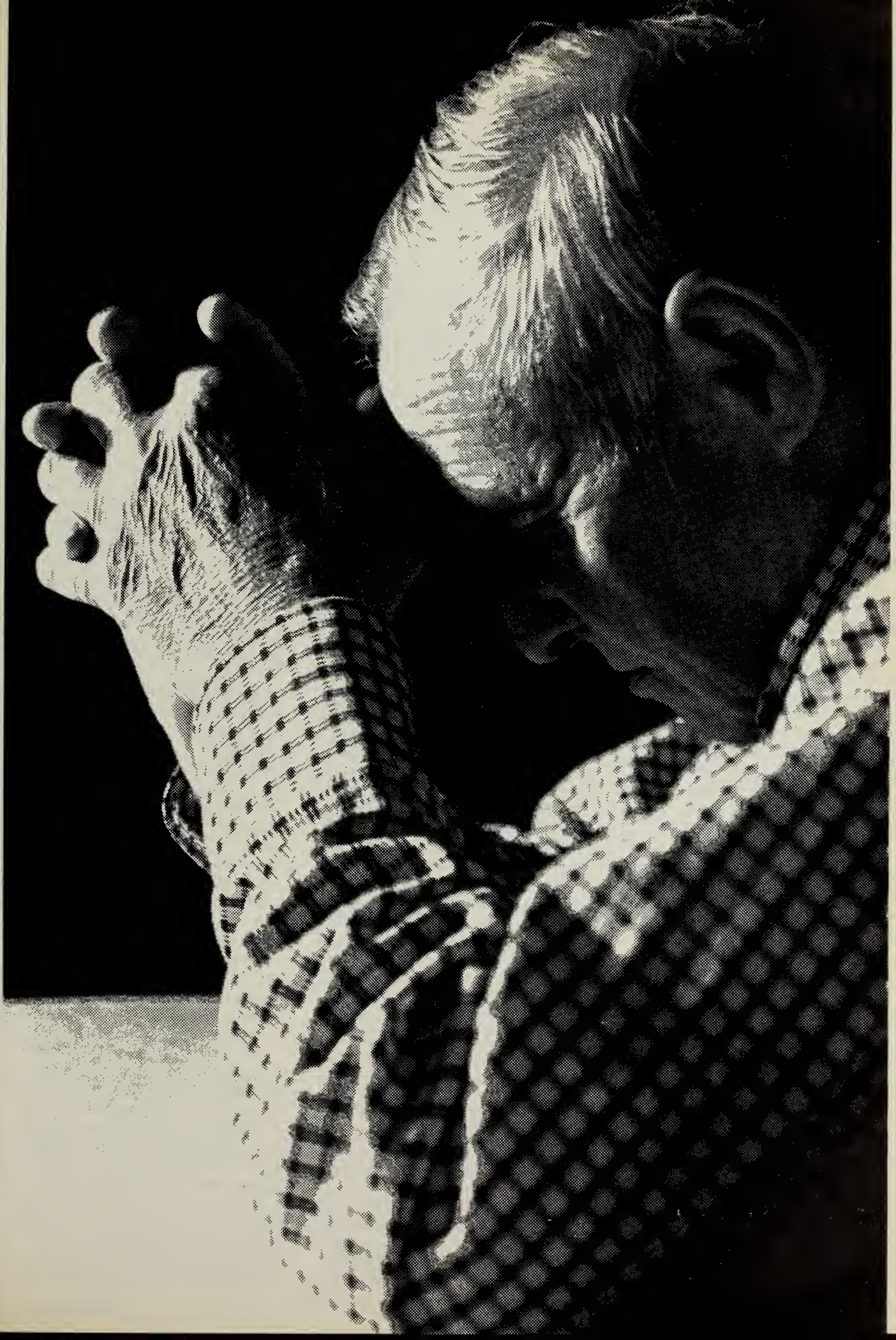
"We know there are two pathological hallmarks that distinguish Alzheimer's disease," says Peter Whitehouse, MD, PhD, a behavioral neurologist and director of the NIA-NIMH Alzheimer Research Center at Case Western Reserve University.

One of these is the neurofibrillary tangles — the accumulation of abnormal fibers on the cerebral cortex — which Alzheimer first described in 1906. The second hallmark is senile plaques, which the electron microscope discovered only recently. These plaques, scattered throughout the cortex, are areas where nerve endings have degenerated and disrupted the passage of electrochemical signals. The appearance of plaques and/or neurofibrillary tangles in a patient is a reliable sign that Alzheimer's disease is present. The larger the number of plaques and tangles in the cortex, the greater the disturbance in intellectual function and memory.

Perhaps the most exciting revelation in medicine's search for a cause of Alzheimer's disease however, came in 1987 when research focusing on chromosome 21 as a possible marker for AD turned out to be valid.

According to the study, carried out by an international research team, led by Peter St. George-Hyslop, MD, of Boston's Massachusetts General Hospital, a consistent abnormality — a buildup of the protein amyloid — was found on chromosome 21, which also carries the defect of Down's syndrome.

"Down's syndrome is caused by an extra chromosome 21," says Dr.



"Clinically, we only diagnose Alzheimer's 63% to 85% of the time. It's a complex and difficult diagnosis to make . . . even for trained specialists."

Whitehouse. "And all victims of Down's syndrome over the age of 35 develop tangles and plaque."

The significance of this discovery moves medicine closer to the theory that AD is hereditary.

"There is still a 50-50 chance that a child of an AD victim will inherit the disease," says Dr. Whitehouse, "but discovery has led to the development of pre-symptomatic testing, so now we can test those who, because of genetic factors, may be predisposed to the disease, and we can make a diagnosis sooner."

There is, as yet, no answer to the question why do these tangles and plaques occur, or why amyloid builds up on some chromosome 21s and not others. Of course, there are theories.

The most common belief, at present, is that the persistent presence of an atypical virus eventually leads to the condition in long-time survivors.

Prion, a virus-like organism, is one substance that researchers have studied recently as a likely suspect, but no conclusive report has ever emerged from these studies.

Then there is the highly controversial belief that an overexposure to aluminum — in drinking water or by cooking on aluminum cookware, or drinking from aluminum cans — causes Alzheimer's.

"No study has ever proven this link," refutes Dr. Whitehouse. "They did a study with miners who mined bulite (one of the base metals used in producing aluminum) and none of them ever developed Alzheimer's."

Still, reputable physicians and medical publications, including *Lancet,* continue to flirt with the theory from time to time.

John Kennedy, MD, a geriatric psychiatrist who works at Case Western's Alzheimer Research Center with Dr. Whitehouse, says that in Norway, researchers there are looking at the prevalence of acid rain and its effect on lakes and drinking water. Attempts are being made to link high levels of acid rain with high levels of dementia. Again, however, no results from that study have been forthcoming.

There may be some reassurance, however, in knowing that medicine is trying every angle, every theory, in determining a reason for Alzheimer's. Perhaps one day, the cause may emerge through process of elimination. Even negative progress is progress.

A difficult diagnosis

Process of elimination is presently the method most physicians must use in diagnosing Alzheimer's disease.

"Yes, it's still very much a diagnosis of exclusion," confirms Dr. Whitehouse.

In other words, after physical, neurological and psychiatric evaluations have confirmed for you what it is *not,* you diagnose Alzheimer's. It's an "iffy" way to make any diagnosis, but for the moment at least, there is no other choice.

"Clinically, we only accurately diagnose Alzheimer's 63% to 85% of the time. It's a complex and very difficult diagnosis to make, even for trained specialists," says Dr. Kennedy.

One of the reasons for this difficulty, of course, is that there are many other health problems that mimic the symptoms of AD. Forgetfulness, for example, may be caused by a number of factors, other than AD. Normal aging, biological depression (which is common in the elderly and the most frequently overlooked problem), vascular disorders, abnormal thyroid function, infections, pernicious anemia, even adverse drug reactions can make its victim appear to be suffering from Alzheimer's disease.

"The differentials are subtle," says Dr. Kennedy, and attempting to sort out the normal forgetfulness of aging from Alzheimer's and Alzheimer's from other forms of dementia is going to become one of medicine's biggest problems in the years ahead.

In a recent article in the *Columbus Dispatch,* John McSweeney, a neuropsychologist at the Medical College of Ohio at

Toledo reported that an increasing number of older people are complaining about memory loss, and national reports state that similar concerns have been made by aging Baby Boomers. That means a good many patients may be showing up in your office in the future, demanding "memory checkups" or some other reassurance that they do not have Alzheimer's disease.

Many of them, of course, will not.

"It's important the Alzheimer's neon sign doesn't flash too brightly, and that other diagnoses are considered," says Neal Cutler of the University of California. Cutler, a neurologist recently featured in news reports, conducted a survey of adults, over 45 years about their knowledge of Alzheimer's.

Dr. Kennedy agrees that one of the dangers of no definitive Alzheimer's test is that other, treatable problems may be overlooked.

Whether or not the "neon sign" of Alzheimer's is flashing too brightly, however, is a matter that may be open to debate.

Over a certain age, Alzheimer's does become a prevalent disorder, says Dr. Kennedy.

"One in three adults, 85 years or older, is likely to become a victim of Alzheimer's," adds Dr. Whitehouse — a frightening statistic when one considers that more and more Americans will be reaching this age in the future.

Of course, Alzheimer's can, and often does, begin at an earlier age.

"I once heard of a case of a 28-year old mother of three who was diagnosed at autopsy with Alzheimer's" says Dr. Kennedy.

Typically, however, the disease begins when patients are in their 50s, and chances of getting the disease increases with age.

"Increasing age is definitely one of the risk factors," says Dr. Kennedy.

So is a positive history of Alzheimer's in a first-generation relative and any evidence of a head injury.

"It's possible that a trauma to the head affects the blood barrier that surrounds and protects the brain," Dr. Kennedy explains. Any weakening of this barrier could allow viruses to enter, creating the conditions of Alzheimer's disease.

As a clinician, then, you assess the risks, run your tests and make an educated guess? Is *that* the best medicine has been able to do?

So far, yes — but research is not

Alzheimer's or Normal Memory Loss?

As more and more Ohioans continue to reach older and older ages, chances are you'll soon be seeing a number of patients in *your* practice complaining of "memory loss," and who are fearful that they are about to become a victim of Alzheimer's disease.

While an accurate diagnosis of Alzheimer's can be difficult to make, say John Kennedy, MD, and Peter Whitehouse, MD, PhD, of the NIA-NIMH Alzheimer Research Center at Case Western Reserve University, there are still ways you can differentiate the memory loss that signals Alzheimer's for the type of forgetfulness that occurs with normal aging.

"Eventually, the person with Alzheimer's is going to appear obviously demented — even to a lay person," says Dr. Kennedy.

If a person walks into a bank, for example, and finds he or she has forgotten the checkbook, that's normal. If the individual forgets what a checkbook is *for*, that may be Alzheimer's.

Alzheimer's, then, is the loss of the ability to store information. As the disease progresses, even the stored facts simply aren't there anymore. Normal forgetfulness may involve delays in retrieving the information — but the information is still there.

"If you find that the memory loss is affecting not just simple things, but the daily life and day-to-day functions of the individual," says Dr. Whitehouse, "it's time for the physician to take charge."

The first line of action would be to refer the patient to a neurologist, a psychiatrist or other specialist skilled in the assessment of the causes of such impairment. Tests will usually include a complete medical history (with anecdotes from family members), a physical exam and a psychological exam which will test the extent of the loss of memory as well as language skills and emotional state.

Then, a course of treatment, including drug therapy if necessary, can be prescribed.

For the patient with what appears to be normal memory loss, you can suggest memory aids, such as calendars, or urge the patient to develop better organizational skills and arrange regular follow-up visits to assess if the problems are stable. Perhaps, however, the reassurance that their problem is a normal one or due to treatable causes — and not the early symptoms of Alzheimer's — is all they really need, or want to hear. — *Karen S. Edwards*

standing still in this area. Researchers have learned, for example, that components of plaques and tangles can be detected in spinal fluid, so examination of samples of spinal fluid may become the definitive test for diagnosing Alzheimer's in the future. Additional studies need to be conducted first, however, and the test itself awaits FDA approval.

"We are still seeking the ultimate diagnostic test," says Dr. Kennedy. He mentions the spinal fluid test as one that is "being looked at," but not yet ready for use.

"CERAD (a consortium for researchers of Alzheimer's disease) is attempting to standardize the method of assessing Alzheimer's," says Dr. Kennedy.

The group also presents "how-to-diagnose Alzheimer's" clinics, and deposits the information and data collected on their patients into a data registry for further study.

There may be nothing positive emerging from their study or any other in the next year . . . or even in the next five years. But, at times, progress can be notoriously slow.

Can Alzheimer's Be Treated?

A wide variety of drugs are currently being studied for the treatment of Alzheimer's disease, including the new drug Tacrine (THA), which seems to hold the most promise.

Tacrine, a cousin of physostigmine but not nearly as toxic, is in clinical trials now at the Alzheimer Research Center at Case Western Reserve University. The center is still looking for appropriate subjects with which to complete their studies. Appropriate, however, is the operative word.

"When this study was first initiated," recalls John Kennedy, MD, of the research center "we had 750 calls from people volunteering as subjects. Over the phone, we were able to screen out all but 30. Of that, only 13 proved to be eligible for the study."

Among the stringent criteria demanded of subjects:

- a minimal amount of medication use
- no serious medical problems
- coherent enough to communicate effectively
- able to attend frequent visits in Cleveland

Both Dr. Kennedy and Peter Whitehouse, MD, also of the center, are hoping to receive referrals from all over the state for this study, not only to provide a broader-based trial, but also "because we're interested in knowing what type of Alzheimer patients are out there," says Dr. Kennedy. "We welcome the involvement of the family and general practitioner in these trials."

Dr. Kennedy hopes that the trials he and Dr. Whitehouse are conducting will shed more light on the subject of Alzheimer's disease.

"Fifteen years from now, we may have a better understanding of dementia because of these trials — the form it takes, and whether or not those forms are genetically inherited. These trials may have important implications in the future — not only for the patients with Alzheimer's, but for their possibly at-risk families as well." — *Karen S. Edwards*

Treat the symptoms . . . you can't treat the disease

Alzheimer's, like AIDS, is one of those medical problems that's extremely frustrating to treat because there is no treatment for the disease itself — just for some of the symptoms that present in each case.

Paul Dusseau, MD, a Columbus physician, wrote an article for *Family Physician* that describes the practitioner's feeling of helplessness when faced with a diagnosis of Alzheimer's.

"When the diagnosis of Alzheimer's disease is confirmed, we must face the patient and his family with a dismal lack of therapeutic options. To date, there are simply no drugs to modify the course of this disease."

But that doesn't mean that medicine isn't trying.

Both Drs. Kennedy and Whitehouse are involved in clinical trials of what looks to be a promising treatment for AD (see sidebar: "Can Alzheimer's Be Treated?"), and researchers in other parts of the country are examining other types of drug therapy.

Most of the research occurring in this area is based on the assumption that acetylcholine or a similar brain chemical problem is the primary cause of AD. If acetylcholine can be restored — or its lack compensated through the use of other chemicals — then, researchers hope, Alzheimer's may be effectively treated if not cured.

So far, however, only slight progress has been made.

In a study at Dartmouth Medical School, for example, the drug bethanechol was injected directly into the brain, and while the results offered some promise, the procedure was deemed too costly and too dangerous to adopt.

Lecithin, says Dr. Whitehouse, is another substance that's being tested.

"Lecithin is actually a food additive — something you could find for sale at a health food store," he says. Lecithin is a natural source of choline, which acts in the brain as a neurotransmitter. While tests continue on this substance, clinically significant results have yet to be seen.

Besides the drug trials, there is another method under investigation which may emerge as a possible treatment of Alzheimer's, and that's gene transplanting — introducing a new gene into the cortex of the individual who is suffering from the disease.

Should heredity prove to be the risk factor researchers currently believe it to be, the success of gene transplantation could be important, not only in treating the disease, but in preventing it as well.

"If pre-symptomatic tests show a patient has a genetic tendency for the disease, it's possible that at some point in the future we can replace the problem-causing gene with a new one," says Dr. Whitehouse.

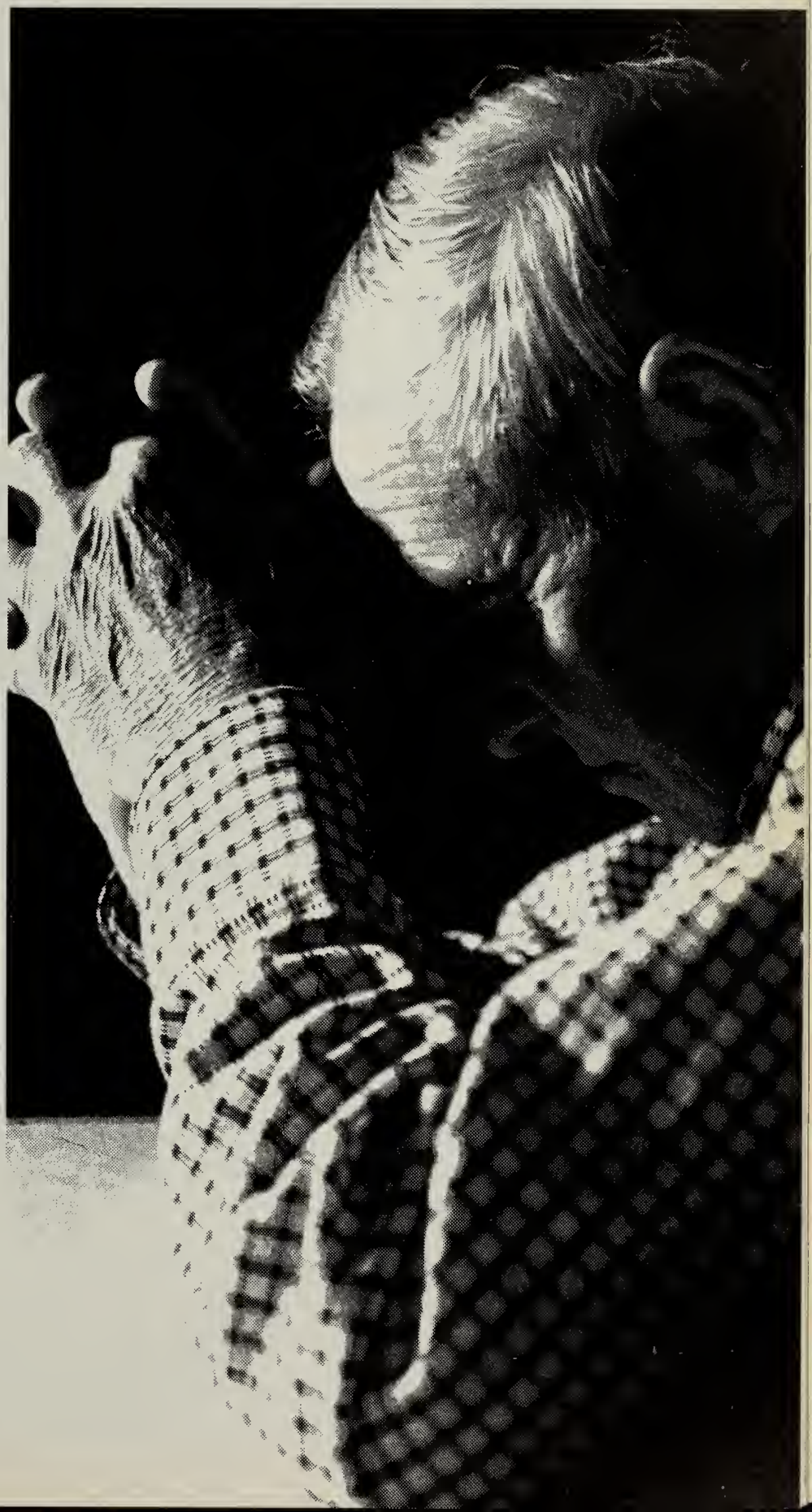
But such procedures, as promising as they sound, are still years away.

So, once a physician makes a diagnosis of Alzheimer's, what can he or she do *now* for the patient?

Referral is probably the first step.

"Referring early is best," says Dr. Kennedy, who points out that a specialist may be better able to recognize and diagnose the reversible problems and prescribe appropriate treatment than the primary care physician.

continued on page 872



PICO AGENCIES

▶ NORTHERN OHIO

Bartlett Insurance Agency
121 East Court Street
Bowling, Green, OH 43402
(419) 352-2574

Benham Insurance Associates
5133 S. Main Street
Southbriar Shopping Center
Sylvania, OH 43560
(419) 882-7117

Brooks Insurance Agency
1120 Madison Avenue
Toledo, OH 43624
(419) 243-1191

Frank B. Hall of Ohio
2603 W. Market Street, Suite 220
Akron, OH 44313
(216) 836-8866 Akron
(216) 452-1366 Canton

The Gluck Agency
2901 Market Street
Youngstown, OH 44507
(216) 788-6577 1-800-362-6577

Haas Insurance Agency
25000 Center Ridge Rd., Suite 4
Westlake, OH 44145
(216) 871-8720

Humphrey & Cavagna Insurance
507 Broad Street
Elyria, OH 44035
(216) 322-5477 1-800-356-8415

Palmer-Blair Insurance Agency
905 Spitzer Building
Toledo, OH 43604
(419) 248-4141

R. Macknin Insurance Agency
3681 Green Rd.
Beachwood, OH 44122
(216) 464-4080

Ron Perkins Insurance Agency
13700 State Road
North Royalton, OH 44133
(216) 237-8200

Sirak-Moore Insurance Agency
P.O. Box 35097
Canton, OH 44735
(216) 493-3211

Stockdale Insurance Agency
24600 Center Ridge, Suite 133
King James Office Park
Westlake, OH 44145
(216) 835-6950

Stolly Insurance Agency
1730 Allentown Road
P.O. Box 1666
Lima, OH 45802
(419) 227-2570

United Agencies
1100 Keith Building
Cleveland, OH 44115
(216) 696-8044

Utz Insurance Agency
P.O. Box 167
Plymouth, OH 44865
(419) 687-6252

W.W. Reed & Son
141 East Main Street
Kent, OH 44240
(216) 673-5838

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Alexander & Alexander of Ohio
1328 Dublin Road
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Columbus, OH 43216
(614) 486-9571

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109 North Fifth Street
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Steubenville, OH 43952
(614) 282-9791

Grubers' Columbus Agency
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P.O. Box 1066
Columbus, OH 43216
(614) 486-0611

Insurance Office of Central Ohio
38 Jefferson Avenue
Columbus, OH 43215
(614) 221-5471

Johnson Insurance Agency
685 North Hague Avenue
Columbus, OH 43204
(614) 276-1600

Marsh & McLennan
10 West Broad Street, Suite 1200
Columbus, OH 43215
(614) 461-6400

McCaffrey Insurance Agency
2935 Kenny Rd., Suite 100
Columbus, OH 43221
(614) 451-3808

Wallace & Turner Agency
616 North Limestone Street
Springfield, OH 45501
(513) 324-8492

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1250 West Dorothy Lane
Suite 108
Kettering, OH 45409
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Cincinnati, OH 45202
(513) 381-3100

Earl F. Mathews
8 North Court Street, P.O. Box S
Athens, OH 45701
(614) 593-5573

FMS Insurance Agency
125 East Court Street, Suite 303
Cincinnati, OH 45202
(513) 381-0811

Hoffman, Ries & Associates
7770 Cooper Road, P.O. Box 42275
Cincinnati, OH 45242
(513) 791-5401

Insurance Associates of Middletown
One North Main Street
Middletown, OH 45042
(513) 424-2481

Joe Hurley Insurance Agency
822 South 7th, P.O. Box 636
Ironton, OH 45638
(614) 532-8712

Miami Valley Insurance Associates
3617 Dayton-Xenia Road
Beavercreek, OH 45432
(513) 429-5600

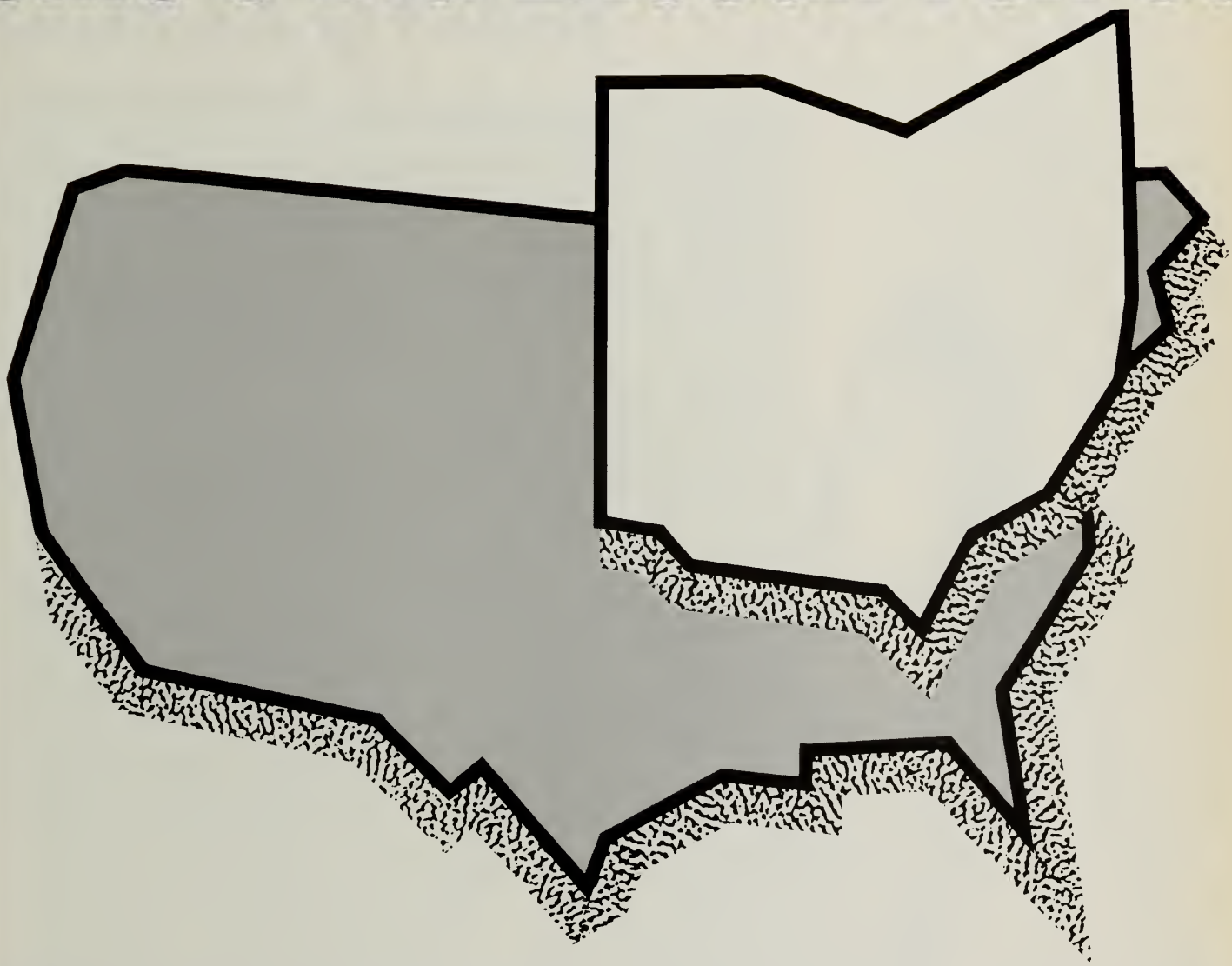
Riffe & Bennett Insurance Agency
422 Center Street
New Boston, OH 45662
(614) 456-4191

Rudd Insurance Agency
239 West Court Street
Cincinnati, OH 45202
(513) 721-7766

SP Agency
1811 Losantiville
Cincinnati, OH 45237
(513) 531-8700

Thomas E. Wood
1500 Carew Tower
Cincinnati, OH 45202
(513) 852-6325

OHIO'S BIG ENOUGH FOR US



Meeting the medical professional liability insurance needs of Ohio physicians—now and in the future—offers ample opportunity, challenge and satisfaction for PICO.

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"I have a feeling that Alzheimer's is overdiagnosed," he adds. "It *is* a common disorder, but I have trouble when a common, biologically-based psychological problem, like depression, is overlooked or considered 'understandable' and, consequently not treated."

If blame is to be placed for overdiagnosing, then perhaps it should fall on the influx of information that has appeared on the subject. As Cutler's study of adults over 45 years verifies, 80% of those interviewed knew of Alzheimer's and 48% were concerned about getting it.

Consequently, many adults are diagnosing themselves and showing up at specialty clinics, like MCO's memory dementia clinic, or in the medical specialist's office.

While this certainly may be a place to start, Dr. Kennedy says that the treatment of Alzheimer's patients is best done at the primary care level especially if the patient is located outside major urban areas.

"We couldn't get along without the primary care physician," says Dr. Kennedy. Beside the fact that there are simply not enough specialists to manage all of the diagnosed Alzheimer's patients, "the family physician knows the patient, knows the patient's family and knows how best to work with those people," Dr. Kennedy says.

Lately, an interdisciplinary approach is being used in the treatment of the Alzheimer's patient.

"The level of care for Alzheimer's patients in the past left much to be desired," says Dr. Kennedy.

Dr. Whitehouse agrees that physician contact with community resources have been inadequate and that a multidisciplinary approach helps to broaden the network of sources available to the physician, the patient and the patient's family.

"All physicians should be aware of the help that the Alzheimer Association can provide as well," says Dr. Whitehouse (see sidebar: "Where To Find Help").

The physician's role on this team, of course, is to provide guidance, and it's the specialist's job, says Dr. Kennedy, to serve as an active team player.

"We want to work as a team member with the family practitioner," says Dr. Kennedy. Obviously, the specialist wants to help in the treatment plan . . . "A good consultation benefits everyone," he says, "but we

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Where To Find Help:

Ohio Alzheimer's Association Chapters

Shirley Bolanz
Akron Tri-County Chapter
220 South Balch Street
Akron, OH 44302
216/253-5533

Phyllis Lanterman
Canton Chapter
Mercy Hall, T.M.M.C.
1320 Timkin Mercy Drive NW
Canton, OH 44708
216/489-1285

Clark-Champaign-Logan Chapter
330 S. Burnett Rd.
Springfield, OH 45505
513/323-4001

Diana Trenkamp
Greater Cincinnati Chapter
644 Linn St., Suite 502
Holiday Office Park
Cincinnati, OH 45203
513/721-4284

Sharen Eckert
Cleveland Chapter
12200 Fairhill Rd.
Cleveland, OH 44120
216/721-8457

Anna Maria Malia
Columbus Area Chapter
2323 W. 5th Ave., Suite 2100
Columbus, OH 43204
614/481-8834

Debbie Pack
East Central Ohio Chapter
109-A E. Main St.
Newark, OH 43055
614/434-5102

Barb Seggerson
Lima Chapter
1650 Allentown Rd.
Lima, OH 45805
419/224-9741

Sharon Bacon
Miami Valley Chapter
128 E. Apple St., Rm. 6827
Dayton, OH 45409
513/220-2124

Julia Henry
Greater Toledo Chapter
2155 Arlington Ave., Rm. 309
Toledo, OH 43604
419/385-3766

Dorothy Barto
Greater Youngstown Chapter
106 S. Broad St.
P.O. Box 321
Canfield, OH 44406
216/533-3300

COUNTY COLLECTION

and Specialty Section

Malpractice: Is physician support failing?

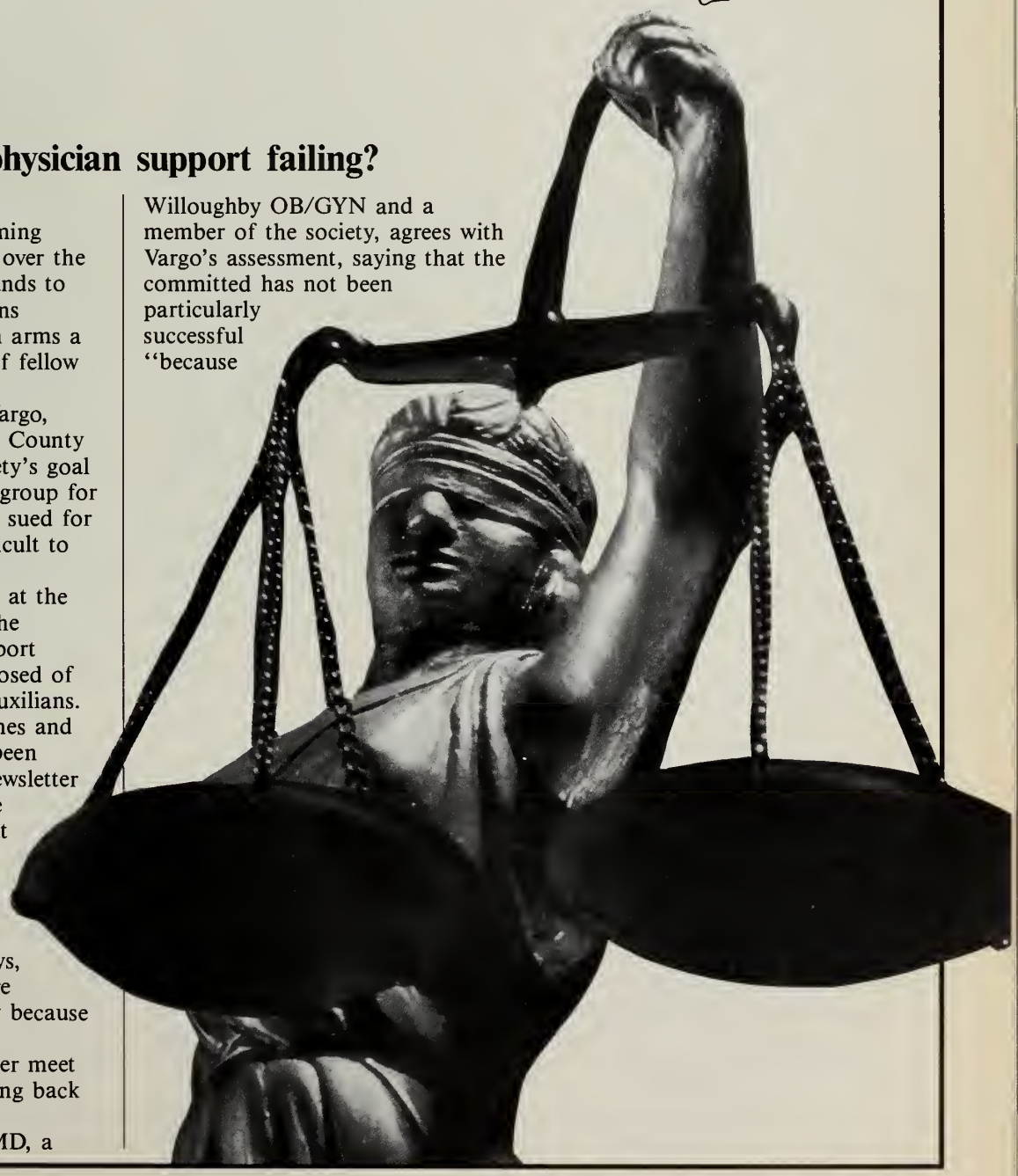
With the threat of malpractice looming larger than ever over the medical community, it stands to reason that most physicians would welcome with open arms a support group made up of fellow physicians.

But according to Jan Vargo, executive director of Lake County Medical Society, her society's goal of establishing a support group for physicians who have been sued for malpractice has been difficult to achieve.

Formed three years ago at the request of a member of the society's council, the support group committee is composed of five physicians and two auxilians. Committee members' names and telephone numbers have been printed in the society's newsletter and are distributed by the auxiliary in the hopes that physicians facing malpractice suits will contact members for emotional support.

The problem, Vargo says, is that she cannot measure the committee's efficiency because everything is confidential; committee members neither meet nor do they report anything back to the society.

Monica MacDougall, MD, a Willoughby OB/GYN and a member of the society, agrees with Vargo's assessment, saying that the committed has not been particularly successful "because



County Collection . . .

and Specialty Section

Malpractice: Is physician support failing? . . . *continued*

it's a passive committee. (Members) are there (only) if doctors request their services."

Although Vargo cannot be sure, she suspects that committee members are not contacted frequently. "We have not had a lot of openness in our community concerning physicians opening up when they're being sued," she explains, adding that she doubts many physicians facing a personal malpractice crisis would feel comfortable discussing their problem with someone they don't know.

Adds Dr. MacDougall, "As you know, most doctors who are sued hide the fact. They don't want anyone to know, sometimes not even their families . . . they're embarrassed, they're humiliated."

That is not to say, however, that the society has been thwarted in its attempts to support its members, or to bring the malpractice crisis to light. On the contrary, Vargo says, the society has found that the best way to support its physicians is on a one-to-one basis.

"The physicians who are very vocal — they have done a lot of one-to-one contact" with physicians being sued, Vargo says. "It's more of a grass-roots effort." Often, she says, physicians eager to offer emotional support will hear of or read about a fellow physician facing a lawsuit and will contact that person personally to offer help.

Dr. MacDougall, who herself has faced a lawsuit, is one such physician. "If I read about a doctor who's been sued, I call them myself," she says, adding that "I've also written them letters or notes" explaining that she was once in a similar position and is willing to help.

"I don't think it hurts to extend the offer," she says. "I think you have to go out and find them."

Sometimes, Dr. MacDougall says, she'll call the physician's spouse. In one instance, she recalls, the wife was immensely relieved because she was worried that her husband was becoming overly depressed about the lawsuit he faced.

When Dr. MacDougall talks with another physician, she often suggests that they increase their exercise level, practice meditation techniques such as deep breathing, listen to soothing music, and discuss the situation and their fears with family members who can support them.

Not all physicians Dr. MacDougall approaches, however, are open about discussing the humiliation of being sued for malpractice. "Some guys will underplay it. I don't think some people are as gut-honest as me," she says, adding that when she was first sued, she sought out other physicians she knew had been through the same experience.

Although they continue to look for ways to beef up the support committee concept, the society is reaching out in other ways to physicians facing lawsuits. That's why the society has supported holding occasional seminars and discussion groups. It's very important, Vargo says, to continue to discuss lawsuits and the emotional drain that accompanies them, to get it out in the open.

> ***"It seems that when you bring the subject up and talk about it . . . the questions start pouring out. It's been kind of a spontaneous reaction rather than a planned reaction."***

"We want to keep the subject in the forefront," she says. "It seems that when you bring the subject up and talk about it — even if it's only for 10 minutes — the questions start pouring out. It's been kind of a spontaneous reaction rather than a planned reaction."

Last April, the society sponsored its first discussion, "A Forum on Feelings," a CME course during which physicians and attorneys discussed the malpractice crisis. Also included was a panel discussion entitled "We've Been There," during

which physicians discussed the feelings of fear and frustration they felt when they learned a patient was suing them. Although Vargo concedes that the first seminar was not very well attended, at the time of this writing, the society plans to hold a similar course in early November.

Dr. MacDougall, who served as a speaker at the first seminar and was scheduled to speak at the second, is a big supporter of discussion groups. As a matter of fact, she says, a state medical association recently contacted her for ideas about setting up its own physician support group. After explaining how Lake County's program was working, she suggested it consider holding yearly seminars dealing solely with malpractice suits.

"What I suggest is that twice a year, have a series of four meetings — one meeting a week for a month," she says. The first meeting, she says, may be a general session, where physicians get to know one another; during the second, a lawyer familiar with malpractice suits should speak; during the third, a mental health professional such as a psychiatrist should speak; and during the fourth session, attendees should be comfortable enough with one another to speak candidly about their fears about their own suits. The reasoning behind holding the seminars, she says, is that "If you do it twice a year, you'll catch people who have just been sued as well as doctors who have already been sued," which will lead to better discussions.

Bob Clinger, OSMA's director of Medical Society and Member Relations and staff support for the Physician Effectiveness Committee, says nothing concrete has been done yet to address the problem at the state level. "How we go about (helping physicians who are being sued) in a practical matter, I don't know," he says, "but the Physician Effectiveness Committee is interested in it.

"It's a concept the committee feels it should be involved in, but so far they haven't mapped anything out." On the other hand, Clinger says, "If someone called and said 'I've been sued for malpractice and I'm going to blow my brains out,' I would do the same things we do" to treat and counsel impaired physicians. Until the committee decides what action to take on the matter, however, Clinger says that "I think the concept of these county societies having physician support groups is super."

Until someone builds a better mousetrap, it appears that the Lake County Medical Society will continue with its educational seminars. And while it's safe to say that one or two meetings won't allay all of a physician's fears and doubts, if nothing else they provide a forum for sharing experiences and emotions.

A case in point, Vargo says, is the physician who stood up and admitted for the first time during the first meeting that he had been going through a lawsuit for two years — something that not even his family was aware of. That incident, she says, illustrates well how many physicians feel alone and isolated when facing a suit, how they hide the suit from peers, friends, even family.

"When we held that conference in April," she sums up, "many physicians left in tears. There were lots of feelings that came out." — *Michelle J. Carlson*

The panic prison

Panic disorders are the topic of a film/video package recently developed by the American Psychiatric Association. The package, entitled "The Panic Prison," includes patient handouts, visual aids and promotional materials in addition to film or video. It is designed for use with lay audiences. APA reports that the package is part of a five-year initiative aimed at increasing public awareness of mental illness and improving public attitudes toward treatment and those who receive treatment. Since 1988, the campaign has provided a platform from which psychiatry delivers its message to the media, the general public, educators, community activists, legislators and policymakers, and health professionals. Each year, campaign activities peak during Mental Illness Awareness Week, a federally enacted event observed during the first week of October. The campaign is funded through a federal grant from The Upjohn Company of Kalamazoo, Mich. APA advises that "The Panic Prison" would be particularly suited for showing in the following settings:

- schools, colleges and universities;
- public libraries and community centers;
- parent and family organizations, self-help and support groups;
- churches, temples and synagogues;
- health-care organizations and facilities and professional associations;
- health fairs and exhibits;
- medical seminars for legislative and business leaders.

Copies of the package are available for $100 from the Ohio Psychiatric Association. For more information please contact the OPA at 1500 Lake Shore Drive, Columbus, OH 43204-3824, (614) 486-2401. — *Carol Wright Mullinax*

County Collection . . .

and Specialty Section

Ohio Society of Anesthesiology holds its Annual Meeting

Above: *Anesthesiologists from around the state convened in Columbus this past September to conduct business, listen to speakers, and attend exhibits.*

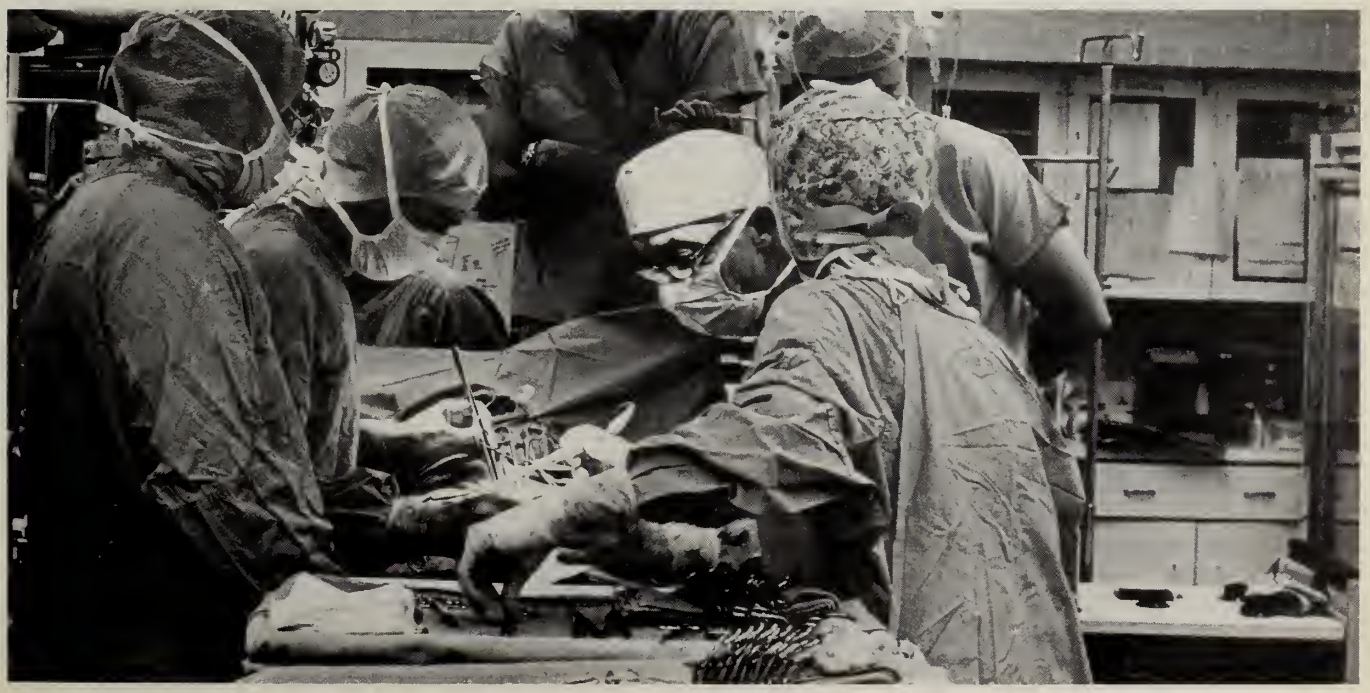
Top right: *Michael Scott, JD was the keynote speaker for the meeting.*

Bottom right: *Over 30 exhibitors demonstrated or showed their wares to those anesthesiologists who attended the meeting.*

The Durable Power of Attorney for Health Care

New legislation allows patients to appoint their own health-care decision-makers . . .

Editor's note: *Senate Bill 13, recently passed by the Ohio General Assembly, has established a new Durable Power of Attorney for Health Care, which allows persons to legally appoint someone to act in their behalf when they are unable to make needed personal health care decisions. The OSMA has developed a Durable Power of Attorney for Health Care form, as a service to its members. The form is printed in its entirety here. The form was also included as a separate brochure in the October issue of the OSMAgram. By completing the order form included with the brochure, OSMA members will be able to order supplies of the form and brochure to distribute to patients free of charge.*



DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Notice to Person Executing This Document

This is an important legal document. Before executing this document, you should know these facts:

This document gives the person you designate (the attorney-in-fact) the power to make **MOST** health care decisions for you if you lose the capacity to make informed health care decisions for yourself. This power is effective only when you lose the capacity to make informed health care decisions for yourself and, notwithstanding this document, as long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions for yourself.

You may include specific limitations in this document on the authority of the attorney-in-fact to make health care decisions for you.

Subject to any specific limitations you include in this document, if you do lose the capacity to make an informed decision on a health care matter, the attorney-in-fact **GENERALLY** will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the attorney-in-fact to make health care decisions for you **GENERALLY** will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

HOWEVER, even if the attorney-in-fact has general authority to make health care decisions for you under this document, the attorney-in-fact **NEVER** will be authorized to do any of the following:

(1) Refuse or withdraw informed consent to health care necessary to maintain your life (unless you are suffering from an illness or injury that is likely to result in imminent death, regardless of the type, nature, and the amount of health care provided);

(2) Refuse or withdraw informed consent to health care necessary to provide you with comfort care (except that, if he is not prohibited from doing so under (4) below, the attorney-in-fact could refuse or withdraw informed consent to the provision of nutrition or hydration to you);

(3) Refuse or withdraw informed consent to health care for you if you are pregnant and if the refusal or withdrawal would terminate the pregnancy (unless the pregnancy or health care would pose a substantial risk to your life, or unless your attending physician and at least one other physician determine, to a reasonable degree of medical certainty, that the fetus would not be born alive);

(4) Refuse or withdraw informed consent to the provision of nutrition or hydration to you, unless, prior to the refusal or withdrawal of that informed consent, your attending physician and at least one other physician record their opinions that the provision of nutrition or hydration would not provide comfort to you, and additionally that either of the following situations exists: Your death is imminent whether or not nutrition or hydration is provided to you, and the nonprovision of nutrition or hydration to you is not likely to result in your death by malnutrition or dehydration; **OR** if nutrition or hydration were provided to you, it could not be assimilated or would shorten your life.

(5) Withdraw informed consent to any health care to which you previously consented, unless a change in your physical condition has significantly decreased the benefit of that health care to you, or unless the health care is not, or is no longer, significantly effective in achieving the purposes for which you consented to its use.

Additionally, when exercising his authority to make health care decisions for you, the attorney-in-fact will have to act consistently with your desires or, if your desires are unknown, to act in your best interest. You may express your desires to the attorney-in-fact by including them in this document or by making them known in another manner.

When acting pursuant to this document, the attorney-in-fact **GENERALLY** will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records. You can limit that right in this document if you so choose.

Generally, you may designate any competent adult as the attorney-in-fact under this document. However, you **CANNOT** designate a physician who is treating you, an employee or agent of a physician who is treating you, or an employee or agent of a health care facility at which you are being treated as the attorney-in-fact under it.

Unless you specify a shorter period in this document, the document and the power it grants to the attorney-in-fact will be in effect for seven years from the date of its execution. However, if you lack the capacity to make informed health care decisions on the date that the document and the power it grants to the attorney-in-fact otherwise would expire, the document and the power it grants will continue in effect until you regain the capacity to make informed health care decisions for yourself.

You have the right to revoke the designation of the attorney-in-fact by giving him oral or written notice of the revocation. You have the right to revoke the authority of the attorney-in-fact to make health care decisions for you by giving oral or written notice of the revocation to your physician or another physician who is providing you with health care. You have the right to revoke this document and the authority granted to the attorney-in-fact under this document by canceling, obliterating, or destroying it with the intent to revoke it, or by doing anything else that clearly communicates your intent to revoke the document.

If you execute this document and create a valid durable power of attorney for health care with it, it will revoke any prior, valid durable power of attorney for health care that you created, unless you indicate otherwise in this document.

This document is not valid as a durable power of attorney for health care unless it either is acknowledged before a notary public or it is attested and signed by at least two adult witnesses who personally know you and who are present when you sign or acknowledge your signature. No person who is related to you by blood, marriage, or adoption, and no person who is entitled to benefit in any way from your death may be a witness. The attorney-in-fact, physicians, and employees or agents of a physician or a health care facility are ineligible to be witnesses.

If there is anything in this document that you do not understand, you should ask your lawyer to explain it to you.

Your attorney-in-fact may need this document immediately in case of an emergency that requires a decision concerning your health care. Either keep this document where it is immediately available to your attorney-in-fact and alternate attorneys-in-fact (if designated) or give each of them an executed copy of this document. You may also want to give your physician an executed copy of this document.

1. DESIGNATION OF ATTORNEY-IN-FACT. I,_____
(your name)

of_____
(your address)

do hereby designate and appoint:_____
(name of your attorney-in-fact)

of_____ Phone:_____
(address of your attorney-in-fact) (telephone of your attorney-in-fact)

as my attorney-in-fact to make health care decisions for me as authorized in this document. For the purpose of this document, "health care decision" means informed consent, refusal to give informed consent or withdrawal of informed consent.

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE. By this document I intend to create a durable power of attorney for health care under Section 1337.11 et seq. of the Ohio Revised Code.

3. GENERAL STATEMENT OF AUTHORITY GRANTED. Subject to any limitations in this document, I hereby grant to my attorney-in-fact full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so subject to the limitations imposed by law. In exercising this authority, my attorney-in-fact shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my attorney-in-fact.

4. SPECIAL PROVISIONS AND LIMITATIONS. In exercising the authority under this durable power of attorney for health care, my attorney-in-fact shall act consistently with my desires, subject to the special provisions and limitations stated below:

_____

_____

_____

_____

_____

(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you should date and sign each of the additional pages at the same time you date and sign this document.)

5. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH. Subject to any limitations in this document (see paragraph 4), my attorney-in-fact has the power and authority to do all of the following:
(a) Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records;
(b) Execute on my behalf any releases or other documents that may be required in order to obtain this information;
(c) Consent to the disclosure of this information.

6. SIGNING DOCUMENTS, WAIVERS, AND RELEASES. Where necessary to implement the health care decisions that my attorney-in-fact is authorized by this document to make, my attorney-in-fact has the power and authority to execute on my behalf all of the following:
(a) Documents purporting to be a Refusal to Permit Treatment or an Intent to Leave Hospital Against Medical Advice;
(b) Any necessary waiver or release from liability required by a hospital or physician.

7. DURATION. This durable power of attorney for health care expires on _____ (Fill in this space ONLY if you want the authority of your attorney-in-fact to end EARLIER than the seven (7) year period described above.)

8. OPTIONAL DESIGNATION OF ALTERNATE ATTORNEYS-IN-FACT. If the person designated as my attorney-in-fact in paragraph 1 is not available or becomes ineligible to act as my attorney-in-fact to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my attorney-in-fact to make health care decisions for me, then I designate and appoint the following persons to serve as my attorney-in-fact to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

A. First Alternate Attorney-in-Fact:_____
(name)

of _____ Phone: _____
(address)

B. Second Alternate Attorney-in-Fact:_____
(name)

of _____ Phone: _____
(address)

9. PRIOR DESIGNATIONS REVOKED. I revoke any prior durable power of attorney for health care.

I sign my name to this Durable Power of Attorney for Health Care on _____ at _____,
(date) (city)

_____ and have attached_____ additional pages hereto each of which is signed and dated by me.
(state)

_____
(you sign here)

(THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS (1) SIGNED BY TWO QUALIFIED WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC. IF YOU HAVE ATTACHED ANY ADDITIONAL PAGES TO THIS FORM, YOU SHOULD DATE AND SIGN EACH OF THE ADDITIONAL PAGES AT THE SAME TIME YOU DATE AND SIGN THIS POWER OF ATTORNEY.)

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Medical Student Seeks World Peace Through Mountain Climbing

By John Kennedy

Charles W. Pruitt, a medical student at The Ohio State University, was one of 12 Americans who took part in an international mountain climbing effort that was designed to foster world peace. The purpose of the July 5-26 climb, under the auspices of the International Physicians for the Prevention of Nuclear War, was to promote intercultural understanding and trust.

"By necessity, the climbers must strive to overcome cultural barriers and learn to trust each other in order to reach a common goal — completion of the climb and, of course, survival," Pruitt said. "We also hope to be a model for global cooperation, which is necessary for the attainment of world peace and survival."

Pruitt, a 25-year-old native of Hinckley, was chosen as one of the American representatives on the basis of an essay. He joined physicians and medical students from the Soviet Union, Canada, South Africa and Iran, as well as the United States, in climbing 15,300 feet to the summit of Mount Kazbek in the Caucasus Mountains near Tblisi.

"By necessity, the climbers must strive to overcome cultural barriers in order to reach a common goal — survival . . ."

The climb was the latest in a series of joint efforts by U.S. and Soviet medical students to promote peace. In 1986, 20 medical students and physicians climbed Mt. Elbrus, the highest peak in Soviet Georgia. Some of the participants found the experience so worthwhile that they have since conducted a canoe trip in Maine and two speaking tours.

It was a visit by some Mt. Elbrus climbers to Columbus last year that first got Pruitt interested in taking part in the Mount Kazbek climb. He is an active member and past vice president of the OSU student chapter of Physicians for Social Responsibility, which sponsored the visit.

In preparation for the trip, Pruitt practiced climbing techniques with the OSU Mountaineering Club and worked out to build strength and endurance. He also sought donations to help defray the approximately $4,000 cost of airfare, lodging and equipment needed for the climb.

The team met in Moscow, then traveled to a youth sport camp in Soviet Georgia, where they trained

for 10 days. Dr. Slava Onischenko, a 53-year-old sports medicine physician from Moscow, led the expedition. Pruitt commented that the whole team learned a great deal from the seasoned climber, a veteran of Mt. Elbrus and Mt. Everest ascents.

Pruitt's roommate, a medical student from Tanzania, soon became his best friend and climbing partner. Together they met and conversed with Soviet team members, who were thrilled to talk with an American. "They had very romantic notions of our way of life," reflected Pruitt. "One of them said to me, 'You come from the paradise of the 20th century,' but I assured him that we had our share of problems too."

The group, now very tight after an intense training period, set off for base camp on July 18th. "The climb was much more difficult than any of us expected. In addition to physical exhaustion, everyone became sick at one point or another during the expedition," Pruitt remembered, "Fortunately, my diarrhea came and went on the first few days of camp. I was healthy for the climb, unlike most of the rest of the team. There was just no time to disinfect the water."

Not everyone completed the ascent, either. A Soviet reporter became delirious at 14,000 feet and had to be left behind. "He didn't even know where he was. We dug a hole in the snow and picked him back up during our descent." Additionally, an American collapsed from exhaustion only a few hundred yards from the peak. Mused Pruitt, "I felt so sorry for him to have to drop out so close to the top. As we approached the summit, we had to stop and catch our breath every five steps."

Pruitt describes reaching the peak as "one of the most wonderful and challenging experiences of my life."

Now that he's back in the States, Pruitt has decided to take a year's leave of absence from medical school in order to travel around Ohio and the Midwest to

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present a slide show and lecture about his experiences. He hopes that those who hear his story, in addition to gaining insight into world peace issues, might help him locate the resources necessary to pay the more than $2,000 he still owes his creditors. Pruitt maintains

A Soviet reporter became delirious at 14,000 feet . . . "He didn't even know where he was."

a positive outlook concerning his financial status. "The experience was well worth going into debt. I'll find the money somewhere, I'm sure."

When asked what the expedition proved, Pruitt offered this thought: "Grass-roots activism is what we need to achieve world peace, and citizen diplomacy is a vital first step toward that end."

John C. Kennedy is a third-year medical student and President of the OSU chapter of OSMA-MSS.

Photo: "Serenity at Sunset," taken by OSMA-member and professional photographer Gary Marmolya, MD, depicts a snow-capped peak of the Canadian Rockies.

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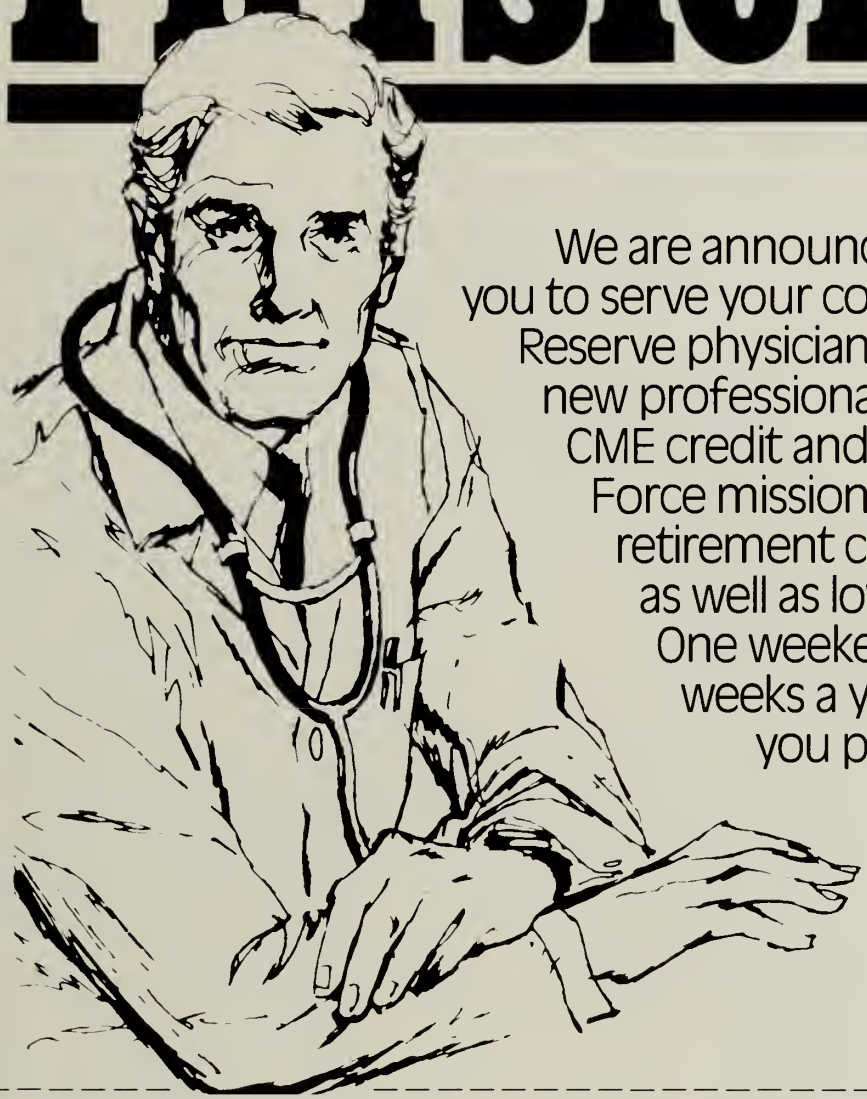

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couldn't work without the primary care physician."

One of the ways the specialist may be able to help is in deciding which medications to use to relieve the symptoms of depression, anxiety and agitation which may or may not occur during the course of the disease.

"You have to walk a fine line here, because you don't want to overmedicate these patients," says Dr. Whitehouse.

Yet certain antidepressants can help a patient through difficult times.

Other steps that might be taken in treating the Alzheimer's patient include:

- Redesigning the patient's environment to help confused patients function more easily at home. (This is where the multidisciplinary approach to treatment becomes useful.) and
- Counseling — for both the patient and the patient's family about future needs, particularly the need to assure the family's control of finances is arranged.

Basically, however, all the physician can do — or hope to do at present — is to delay the ultimate progress of the disease.

"Right now, there is nothing on the horizon that looks like a cure," says Dr. Kennedy.

Yet studies continue to be done, and research continues to keep medicine moving forward. Progress *is* being made.

"It's a slow process," admits Dr. Whitehouse.

But, then, even tortoises have been known to win a race or two. **OSMA**

Karen S. Edwards is Executive Editor of **OHIO Medicine.**

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Ninth Annual Continuing Education Course on Administration in Mental Health-Care Systems

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Fee: $450
Sponsor: Department of Psychiatry, Wright State University School of Medicine
Contact: Paul Rodenhauser, MD, Department of Psychiatry, Wright State University School of Medicine, P.O. Box 927, Dayton, Ohio 45401-0927, 513-276-8325

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Nutrition for Clinical Practice and Everyday Living

When: December 8-9, 1989
Where: Hyatt on Capitol Square, Columbus, Ohio
Credit: 10.5 hours, Category I
Fee: $125 if before November 28, $135 after Nov. 28
Sponsor: The Ohio State University Center for Continuing Medical Education
Contact: The Ohio State University Center for CME, 614-292-4985 or (800) 492-4445

OBITUARIES

ELSE BELL, MD, Michigan City, IN; State University of New York Upstate College of Medicine, Syracuse, NY, 1938; age 87; died August 9, 1989; member OSMA.

JESS F. BOND, MD, Akron; Jefferson Medical College of Thomas Jefferson University, Philadelphia, PA, 1952; age 65; died August 23, 1989; member OSMA and AMA.

DONALD J. BRUGGER, MD, Canton; Ohio State University College of Medicine, 1952; age 71; died August 16, 1989; member OSMA and AMA.

THOMAS V. CEFALU, MD, Barberton; Facolta di Medicina e Chirurgia dell 'Universita di Palermo, Palermo, Italy, 1953; age 65; died September 5, 1989; member OSMA.

SYLVESTER S. DAVIS, JR., MD, Shaker Heights; Howard University College of Medicine, Washington, D.C., 1953; age 64; died August 17, 1989; member OSMA and AMA.

BURGESS E. DEMUTH, MD, Lynbrook, NY; Ohio State University College of Medicine, 1928; age 89; died August 15, 1989; member OSMA and AMA.

NORMAN GLAZER, MD, Cleveland; St. Louis University School of Medicine, St. Louis, MO, 1945; age 68; died August 14, 1989; member OSMA.

ROBERT H. JACKSON, MD, Cleveland; Medizinische Fakultaet der Universitaet Heidelberg, Heidelberg, Baden-Wurttemberg Germany, 1953; age 66; died August 19, 1989; member OSMA and AMA.

DOMENIC MALTA, MD, Youngstown; Facolta di Medicina e Chirurgia dell 'Universita di Bologna, Bologna, Italy, 1958; age 61; died August 5, 1989; member OSMA and AMA.

LELAND D. MCBRIDE, MD, Hillsboro; University of Cincinnati College of Medicine, 1941; age 74; died July 30, 1989; member OSMA and AMA.

PAUL A. SCHUSTER, MD, Cincinnati; University of Cincinnati College of Medicine, 1945; age 68; died August 19, 1989; member OSMA.

GUS S. SHAHEEN, MD, Canton; University of Cincinnati College of Medicine, 1940; age 75; died August 28, 1989; member OSMA and AMA.

CHARLES E. SKINNER, JR., MD, Galion; Columbia University College of Physicians and Surgeons, New York, NY, 1943; age 70; died August 19, 1989, member OSMA.

VINTON C. YOUNG, MD, Brookville; St. Louis University School of Medicine, St. Louis, MO, 1954; age 66; died August 3, 1989; member OSMA and AMA.

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The winning entries will also be published in *OHIO Medicine*.

All entries should be no more than 10 typed, double-spaced pages in length, and should be sent to:

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"Medical Writing Contest"
1500 Lake Shore Drive
Columbus, Ohio 43204-3824.

Cinderella daydreaming at the fireplace.[3]
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Cinderella Dermatosis

(ashy dermatosis, erythema dyschromicum perstans, dermatosis cenicienta, erythema chromicum figuratum melanodermicum[1]*)*

By Alvin Rodin, MD

Ashy dermatosis is characterized by nonspecific, ash-colored macules scattered on the skin, macules, with shadings of greyish pigment and varying in size from one cm. to very large plaques. Histologic changes consist of follicular hyperkeratosis, decreased melanin, vacuolation of some epidermal cells, degeneration of the basal layer and a perivascular dermal infiltrate.[1] Ashy dermatosis appears in early adult life, coming in successive outbreaks.[2] It is more common in South America than in the northern sections of the hemisphere. The cause is not known, and there has been no response to treatment.

The ash-like lesions do not occur on the scalp, palms and toes, unlike those of Cinderella, whose name is derived from her habit of sitting by the fireplace.[3] "When her work was done, Cinderella would creep to the chimney corner and sit there in the ashes." Cinderella is the heroine of a world-wide folk story with hundreds of variations, the oldest one known being a ninth century Chinese version.[4] English variations are derived from translations from the French of Charles Perrault's "Cinderillon" in his 1697 collection of "Tales of Mother Goose."[3] The plot is one variant of the universal theme of boy meets girl, boy loses girl, boy finds girl, to live happily ever after.

The name Cinderella has also been usurped for areas of medicine that are considered to be neglected or overlooked. So-called have been an amazing cornucopia of medical items: colorectal surgery, cancer of the uterus, endocrinology, forensic medicine, fractures, general practice, geriatrics, geriatric nursing, health promotion, the history of pharmacy, hyperbaric oxygen therapy, Listeria monocytogenes, mental retardation, occupational medicine, postnatal care, postoperative

analgesia, preventative medicine, primary health care, rheumatology, hepatitis A virus and the physically handicapped. **OSMA**

References

1. Knox, J.M. et al: Erythema Dyschromicum Perstans: *Arch. Derm.*, 97:262-272, 1968.
2. Ramirez, C.O.: The Ashy Dermatosis (Erythema Dyschromicum Perstans) — Epidemiological Study and Report of 139 Cases: *Cutis,* 3:244-247, 1967.
3. Perrault, C.: *Cinderella or The Little Slipper.* N.Y., Henry Z. Walck, 1971.
4. *Encyclopedia Britannica:* Micropoedia: 15th ed., Chicago, II:940.

From: Rodin, A.E. & Key, J.D.: Medicine, Literature and Eponyms. An Encyclopedia of Eponyms Derived From Literary Characters: Malabar, FL, Robert E. Krieger, 1989.
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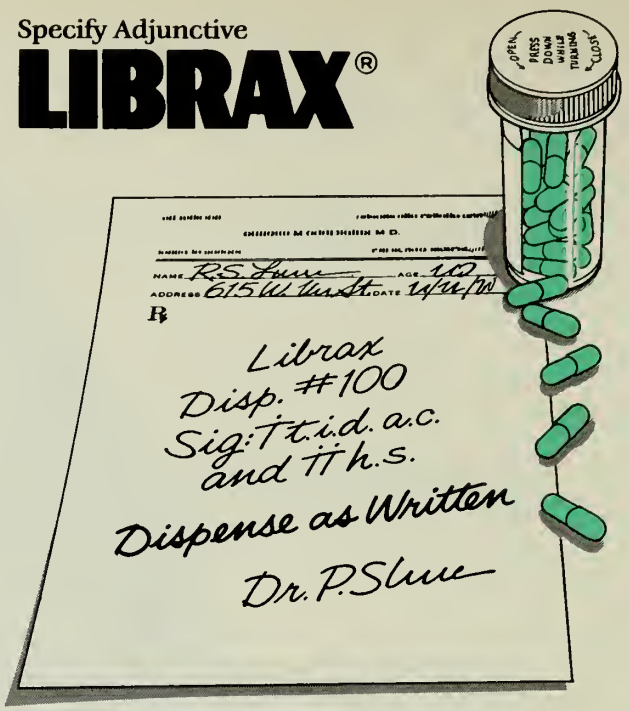

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Organized Medicine and Its Value to Medical Students

By Jane Uva

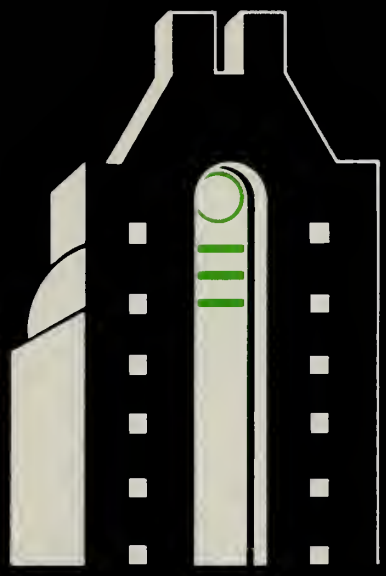
What is it like for a medical student to be in medical school? How many times have we been asked this question and how can we as medical students explain it? Well, the first and second years submerse us into memorizing thousands of pages of anatomy, physiology, biochemistry, pathology, and the list goes on. In this process we lose sleep, contact with family and friends, and touch with what is going on outside of the classroom. All of these are sacrificed to learn millions of facts that appear to be of little relevance but are needed to pass the ever dreaded National Boards. The third and fourth years are even more challenging because we go onto the wards. Here we are up 36 hours or more at a time, being interrogated about things such as, "What nerve innervates the abductor pollicus longus muscle?" Working on real patients allows us to once again lose sleep, freedom and self-esteem. All of this pressure and competition is supposed to build character so that we can perform under the pressures of a medical emergency. Clearly, being a medical student is not a bed of roses. Getting lost in the rat race is as easy as stepping on the cracks in the sidewalk. These hardships experienced by medical students underline the need for a positive experience such as becoming involved in organized medicine.

What is organized medicine? Organized medicine is how intelligent, energetic, compulsive and highly motivated medical students can get more out of their medical education than just the MD behind their names. Organized medicine on a national level falls under the title of the American Medical Association (AMA). The Ohio State Medical Association (OSMA) is the state equivalent of organized medicine. Organized medicine, in other words, is a national and state forum where medical students can voice opinions and make medical policy. The goals of organized medicine are many. Three of the most prominent goals are: (1) to present medical students' perspectives that directly involve them to the AMA; (2) to expand medical student membership and participation; and (3) to stimulate the ethical conscience of policymakers in organized medicine. One benefit of being involved in organized medicine in Ohio is that Ohio is the only state that pays medical student membership dues for both the AMA and the OSMA.

Prior to 1950, there was no membership provision for medical students. Today, however, there is the AMA-MSS (Medical Student Section) where medical students can voice their opinions. Likewise, the MSS gives medical students the opportunity to view challenges and issues that face them in the future. Getting involved allows medical students the chance to promote change and influence the future. Furthermore, medical students now have a seat on all of the AMA councils, which includes voting privileges. As a result, medical students have direct input into decisions made by the AMA.

As a medical student you can become involved in all levels of the organization. One way to become involved in the organization and directly impact future health care decisions is to write a resolution. Writing a resolution is an invaluable experience because it allows medical students to work on their neglected, but needed, writing, research and organizational skills. Speaking on the resolution at conferences further enhances effective speaking and negotiation skills. Both writing and speaking on a resolution forces a medical student to become adept in parliamentary procedure. Medical students have been very successful in molding our health-care policy. One prime example is the current strict regulation of smoking on airplanes.

continued on page 894



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"Meeting other students undoubtedly fine-tunes one's people skills . . . meeting leading physicians is one of the best ways to grasp the hottest debates . . ."

One member from each medical school in the U.S. is a voting member in the AMA House of Delegates. The delegate and the alternate delegate positions allow students first-hand access to policymaking decisions, thus increasing a medical student's leadership skills. There are many other leadership positions available for medical students. On the national level, for example, there are six seats on the Governing Council. These students oversee the regular activities of the annual MSS meeting as well as appoint medical students to the nine AMA councils. Since 1984, medical students have even had a seat on the Board of Directors of the AMA. Consequently, there are numerous national leadership positions available.

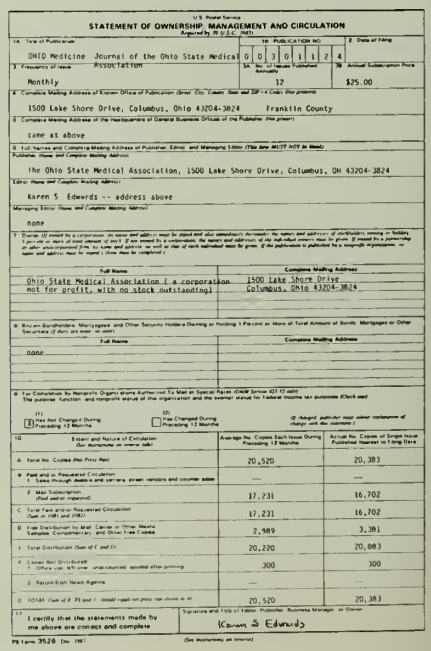
Another value of being involved in organized medicine is the chance to go to annual conferences. These conferences enable medical students to broaden their knowledge on national health-care issues. Similarly, medical students from the 50 states are represented, hence these conferences are an excellent opportunity to meet new and different students from all over the U.S. Meeting other students at these conferences undoubtedly fine-tunes one's people skills. Meeting leading physicians at these conferences is one of the best ways to grasp the hottest debates, which in turn can lead to future networking in the organization.

Organized medicine supports and encourages students to initiate and participate in student projects. One outstanding example is the "Student to Student" project. This project is a statewide health education program sponsored by the OSMA-MSS. Medical students involved in this project talk about current health topics to preschool, elementary, junior high, senior high and college students. Several benefits in being involved in this project are increasing overall understanding of the topics addressed, increasing ability to teach and answer questions about health-related issues and increasing the effectiveness of communication skills. Involvement in this type of program is both challenging and fun.

Finally, joining the OSMA and the AMA entitles medical students to the same benefits as physicians. For example, medical students receive *JAMA Pulse, OHIO Medicine, AMA News* and other medical publications, all free of charge. These are valuable educational sources.

Being a student in medical school is not an easy path, yet the medical education is unparalleled by any other. One way to enhance your medical education outside of the classroom is to become involved in organized medicine. Many essential skills and an enormous amount of useful knowledge can be learned through experience in the AMA and the OSMA. Additionally, students can work on solving problems that directly affect them. Furthermore, students who are concerned about the future of medicine can help shape the health-care system in which they will practice. Lastly, medical students are able to enhance the medical profession and consequently impact the future of medicine by becoming an integral and active member in organized medicine.

Jane Uva is co-director of Wright State University's Student-to-Student program.



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1A. Title of Publication: OHIO Medicine Journal of the Ohio State Medical

1B. PUBLICATION NO.: 0 0 3 0 1 1 2 4

2. Date of Filing

3. Frequency of Issue: Monthly

3A. No. of Issues Published Annually: 12

3B. Annual Subscription Price: $25.00

4. Complete Mailing Address of Known Office of Publication (Street, City, County, State and ZIP+4 Code) (Not printers): 1500 Lake Shore Drive, Columbus, Ohio 43204-3824 Franklin County

5. Complete Mailing Address of the Headquarters or General Business Offices of the Publisher (Not printer): same as above

6. Full Names and Complete Mailing Address of Publisher, Editor, and Managing Editor (This item MUST NOT be blank)

Publisher (Name and Complete Mailing Address): the Ohio State Medical Association, 1500 Lake Shore Drive, Columbus, OH 43204-3824

Editor (Name and Complete Mailing Address): Karen S. Edwards -- address above

Managing Editor (Name and Complete Mailing Address): none

7. Owner (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address as well as that of each individual must be given. If the publication is published by a nonprofit organization, its name and address must be stated.) (Item must be completed.)

Full Name	Complete Mailing Address
Ohio State Medical Association (a corporation not for profit, with no stock outstanding)	1500 Lake Shore Drive Columbus, Ohio 43204-3824

8. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages or Other Securities (If there are none, so state)

Full Name	Complete Mailing Address
none	

9. For Completion by Nonprofit Organizations Authorized To Mail at Special Rates (DMM Section 423.12 only)
The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes (Check one)

(1) [X] Has Not Changed During Preceding 12 Months
(2) [ ] Has Changed During Preceding 12 Months

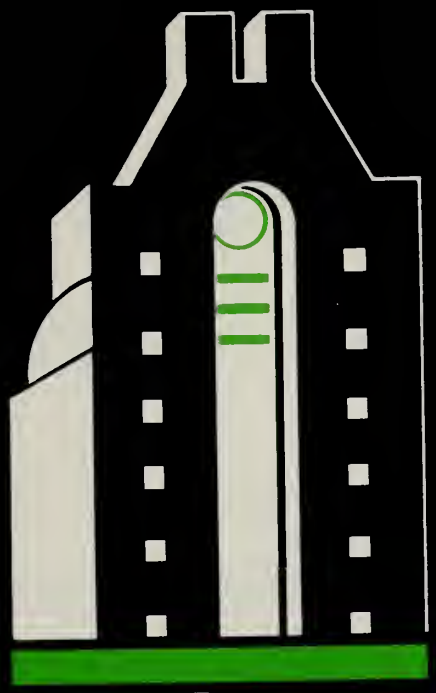
(If changed, publisher must submit explanation of change with this statement.)

10. Extent and Nature of Circulation (See instructions on reverse side)	Average No. Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
A. Total No. Copies (Net Press Run)	20,520	20,383
B. Paid and/or Requested Circulation 1. Sales through dealers and carriers, street vendors and counter sales	—	—
2. Mail Subscription (Paid and/or requested)	17,231	16,702
C. Total Paid and/or Requested Circulation (Sum of 10B1 and 10B2)	17,231	16,702
D. Free Distribution by Mail, Carrier or Other Means Samples, Complimentary, and Other Free Copies	2,989	3,381
E. Total Distribution (Sum of C and D)	20,220	20,083
F. Copies Not Distributed 1. Office use, left over, unaccounted, spoiled after printing	300	300
2. Return from News Agents	—	—
G. TOTAL (Sum of E, F1 and 2 - should equal net press run shown in A)	20,520	20,383

11. I certify that the statements made by me above are correct and complete.

Signature and Title of Editor, Publisher, Business Manager, or Owner: Karen S. Edwards

PS Form 3526, Dec. 1987 (See instructions on reverse)



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Steps Toward More Defensible Medical Records

The Loss Awareness Bulletin is provided each month through the OSMA's Task Force on Professional Liability and its Subcommittee on Loss Awareness.

In reviewing some of the more perplexing factors involved in malpractice litigation, defense attorneys often cite the weaknesses found in medical records — and charting procedures that are not sufficiently accurate, complete or concise.

The documentation that physicians generate in the care and management of patients can be a strong defense in the courtroom — or a formidable obstacle — should a claim of medical negligence arise.

Medical records that become a physician's ally in the courtroom have certain characteristics. They are, in the most general sense, maintained in a manner that is legible, chronological and factually reliable.

There are other reflections of good documentation — practices that bolster the usefulness of medical records in the office and, when necessary, in the courtroom setting.

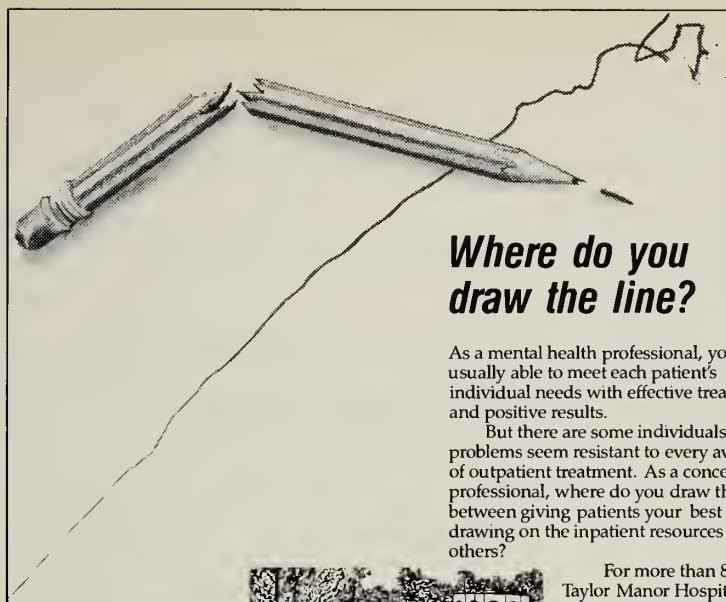
- **A defensible medical record indicates why the patient has sought care.**
  Records often are not clear enough in pinpointing the motivation for the patient's request for medical service, nor do they clearly present symptomatology.
- **A defensible medical record indicates what is wrong.**
  Frequently, records contain little or no information about the physical evidence that influences diagnosis and the plan for treatment. Statements or even brief quotes from the patient about what is wrong are important additions to the record, as well as how this is physically manifested based upon the physician's examination.
- **A defensible medical record indicates the thought process used in establishing a range of possible conditions.**
  The increase in malpractice lawsuits alleging failure or delay in diagnosis makes proper documentation of differential diagnosis even more vital. Reference to the spectrum of possible illnesses, if absent from the medical record, can weaken defensibility. Such omission may be perceived as indication that the physician has overlooked the possibilities — or perhaps lead to allegations that the defendant has even overlooked the obvious.
- **A defensible medical record clearly indicates the methods of treatment the physician and the patient have selected.**
  Medical records that present problems in litigation often are those in which the plan of care is not easily determinable from notes, either handwritten or dictated.
- **A defensible medical record will indicate clearly that the plan of care has been monitored regarding effect on the condition being treated.**
  The first and best time to emphasize the need for follow-up is when the patient is *in* the office or *in* the physician's presence. Marking the billing record with return dates will only partially fulfill the process of instruction for follow-up care.
- **A defensible medical record will indicate clearly that the patient comprehends and authorizes the plan of care, either medical or surgical.**
  As part of informed consent, patients need to be provided with understandable information about the choices available for care, and grant permission to the physician to accomplish that choice.

Since medical records become legal documents, admissable as evidence, they are subject to scrutiny of the greatest — and smallest — detail. Some claims have become seriously compromised, if not indefensible, because of inadequate medical records that had partial or missing entries; that included improper alterations; or were illegibly maintained.

Evaluating the proof of documentation involves reality as

well as perception. For example, records that are weak can damage a physician's defense because juries often will believe that "care not charted is care not performed." The same applies to lack of documentation that explains the physician's basis for arriving at a diagnosis and course of treatment.

These suggestions are designed to help reduce the weaknesses often found in medical records — problems that unfortunately can play a major part in malpractice litigation. Records that include the elements discussed above may only require a minimal amount of added time, while offering the physician maximum protection regarding what is said, meant and understood in the course of treating a patient. **OSMA**



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OHIO STATE MEDICAL ASSOCIATION

Report on Examination of Financial Statements for the Years Ended December 31, 1988 and 1987

REPORT OF INDEPENDENT ACCOUNTANTS

The Committee on Auditing and Appropriations
Ohio State Medical Association
Columbus, Ohio

We have audited the accompanying balance sheets of the Ohio State Medical Association as of December 31, 1988 and 1987, and the related statements of revenue and expenses, changes in fund balance, and cash flows for the years then ended. These financial statements are the responsibility of the Association's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Ohio State Medical Association as of December 31, 1988 and 1987, and the results of its operations and its cash flows for the years then ended in conformity with generally accepted accounting principles.

Coopers & Lybrand

Columbus, Ohio
April 28, 1989

OHIO STATE MEDICAL ASSOCIATION
BALANCE SHEET, December 31, 1988 and 1987

ASSETS	1988	1987
Current assets:		
Cash and cash equivalents (Note 1)	$1,302,849	$2,808,570
Short-term investments (Note 2)	3,086,703	
Total cash and short-term investments	4,389,552	2,808,570
Accounts receivable	96,116	126,661
Accrued interest receivable	67,708	39,717
Prepaid expenses	45,994	39,422
Total current assets	4,599,370	3,014,370
Other assets:		
Marketable securities (Notes 2 and 3)	1,145,370	1,285,730
Notes receivable	69,491	131,250
Investments:		
Physicians Insurance Company of Ohio (PICO), at cost (Notes 4 and 5)	100,000	100,000
Real estate (building — $2,090,000; equipment — $260,000; net of accumulated depreciation of $430,375 in 1987 (Note 5)		1,919,625
Other investments		46,497
	1,314,861	3,483,102
Property and equipment, at cost (Notes 1, 5 and 6):		
Building		572,481
Data processing equipment	357,852	215,229
Furniture, fixtures and office equipment	361,402	148,876
	719,254	936,586
Less accumulated depreciation and amortization	(327,904)	(445,683)
	391,350	490,903
Land		448,628
	391,350	939,531
	$6,305,581	$7,437,003

The accompanying notes are an integral part of the financial statements.

LIABILITIES AND FUND BALANCE

	1988	1987
Current liabilities:		
Accounts payable and accrued expenses	$ 150,045	$ 165,711
Current portion, term debt (Note 5)		17,696
Current portion, capital lease obligations (Note 6)	36,109	10,095
Dues collected in advance for related societies in the federation	704,765	799,989
Accrued pension expense (Note 7)		104,531
Total current liabilities	890,919	1,098,022
Long-term obligations:		
Term debt (Note 5)		2,425,494
Capital lease obligations (Note 6)	94,129	21,813
	94,129	2,447,307
Deferred membership dues (Note 1)	1,128,273	837,285
Fund balance (Note 3):		
Designated funds	1,006,196	906,702
Undesignated funds	3,186,064	2,147,687
Total fund balance	4,192,260	3,054,389
	$6,305,581	$7,437,003

The accompanying notes are an integral part of the financial statements.

STATEMENT OF REVENUE AND EXPENSES
for the years ended December 31, 1988 and 1987

	1988	1987
Revenue:		
Membership dues (Notes 1, 4 and 9)	$3,657,103	$3,666,523
Exhibit fees	4,000	4,800
Annual meeting	19,875	45,510
Fees for collection of AMA dues	11,015	17,005
CME accreditation and courses	56,903	30,679
Ohio State Medical Journal (Note 9)	212,222	228,642
Interest	440,182	360,707
Rental income	4,884	3,800
Services to specialty societies	69,327	68,237
Legislative policy fund contributions	900	153,414
Other, net	166,447	142,650
Total revenue	4,642,858	4,721,967
Departmental operating expenses:		
Administration	688,908	581,481
Education, specialty societies and meeting management	700,156	743,210
Health education	187,570	164,684
Membership	254,240	207,334
Government relations	140,780	176,457
Communications	824,747	769,486
Development and member services	310,029	272,732
State legislation	503,901	495,378
Legal services	308,252	263,072
Finance	265,042	190,433
EDP	163,246	142,955
Total expenses	4,346,871	4,007,222
Excess of revenue over expenses before loss from lease to related party and sale of buildings and land	295,987	714,745
Gain on sale of buildings and land (Note 5)	876,622	
Loss from lease to PICO (Note 5)	(34,738)	(53,264)
Excess of revenue over expenses	$1,137,871	$ 661,481

The accompanying notes are an integral part of the financial statements.

STATEMENT OF CHANGES IN FUND BALANCE
for the years ended December 31, 1988 and 1987

	Total	Designated Funds	Undesignated Funds
Balances, January 1, 1987	$2,392,908	$ 761,681	$1,631,227
Excess of revenue over expenses	661,481		661,481
Additions to designated funds		198,736	(198,736)
Expenditures from designated funds		(53,715)	53,715
Balances, December 31, 1987	3,054,389	906,702	2,147,687
Excess of revenue over expenses	1,137,871		1,137,871
Additions to designated funds		99,494	(99,494)
Balances, December 31, 1988	$4,192,260	$1,006,196	$3,186,064

The accompanying notes are an integral part of the financial statements.

STATEMENT OF CASH FLOWS
for the years ended December 31, 1988 and 1987

	1988	1987
Cash flows from operating activities:		
Excess of revenue over expenses	$1,137,871	$ 661,481
Adjustments to reconcile excess revenue to net cash provided by operating activities:		
Depreciation and amortization	97,924	115,438
Gain on sale of buildings and land	(876,622)	
Loss on investment	25,000	805
Changes in assets and liabilities:		
Decrease (increase) in accounts receivable	30,545	(1,563)
(Increase) decrease in accrued interest receivable	(27,991)	3,579
Increase in prepaid expenses	(6,572)	(987)
Decrease in accounts payable and accrued expenses	(15,666)	(95,384)
Decrease in dues collected in advance for related societies in the federation	(95,224)	(128,242)
Decrease in accrued pension expense	(104,531)	(20,292)
Increase (decrease) in deferred income	290,988	(138,727)
Net cash provided by operating activities	455,722	396,108
Cash flows from financing activities:		
Repayment of term debt and lease obligations	(2,470,295)	(16,839)
Cash flows from investing activities:		
Maturities (purchases) of noncurrent marketable securities	140,360	(302,086)
Purchases of short-term investments	(3,086,703)	
Decrease in notes receivable	915	23,509
Additions to property and equipment, net	(229,714)	(19,906)
Proceeds from sale of buildings and land	3,683,994	
Cash flows provided by (used in) investing activities	508,852	(298,483)
(Decrease) increase in cash and cash equivalents	(1,505,721)	80,786
Cash and cash equivalents:		
Beginning of year	2,808,570	2,727,784
End of year	$1,302,849	$2,808,570
Supplemental disclosures of cash flow information:		
Cash paid during the year for:		
Interest (principally related to debt on building leased to PICO)	$ 129,108	$ 354,155
Supplemental schedule of noncash activities:		
Capital lease obligations incurred for new equipment	$ 125,435	$ 33,266

The accompanying notes are an integral part of the financial statements.

NOTES TO THE FINANCIAL STATEMENTS

1. **Accounting Policies:**

The following is a summary of certain significant accounting policies followed in the preparation of the financial statements of the Ohio State Medical Association (the Association). The policies conform to generally accepted accounting principles and have been consistently applied.

a. **Property and Equipment:**

Property and equipment are stated at cost. The Association recognizes depreciation and amortization on the straight-line method in amounts adequate to amortize costs over the estimated useful lives of the assets as follows:

Data processing equipment ..... 5 years
Furniture, fixtures and equipment ..... 10 years

Expenditures for major betterments are capitalized and repairs and maintenance are expensed. Disposals of fixed assets are accounted for as reductions to cost and accumulated depreciation. Any resulting gain or loss is credited or charged to other income.

b. **Deferred Membership Dues:**

Income from annual membership dues is recognized in the calendar year to which the dues apply.

c. **Exemption — Federal Taxes on Income:**

The Association is exempt from federal taxes on income under Section 501(c)(6) of the Internal Revenue Code. Unrelated business income is, however, subject to federal income tax. Because amounts deductible exceed such unrelated business income, there has been no provision for income tax expense in 1988 and 1987.

d. **Cash Equivalents:**

For purposes of reporting cash flows, the Association considers all highly liquid debt instruments purchased with a maturity of three months or less to be cash equivalents.

e. **Reclassifications:**

Certain amounts in the 1987 financial statements have been reclassified to conform to the current year presentation.

2. **Short- and Long-Term Investments:**

The Association invests in short- and long-term investments. Short-term investments which are recorded at cost which approximates market, consist of the following at December 31, 1988:

Certificate of deposit	$ 250,000
Bankers acceptances	2,836,703
	$3,086,703

Long-term investments, which consist solely of marketable debt securities, are carried at amortized cost, since it is the Association's intention to hold these investments for income yield until maturity. The Association previously recorded such investments at the lower of aggregate cost or market utilizing a valuation allowance that is not significant to the financial statements. Such investments are composed of the following types of marketable securities for the year ended December 31.

	1988	1987
United States Treasury notes	$ 760,418	$ 910,721
Federal Home Loan Bank bonds	322,968	331,406
	$1,083,386	$1,242,127

At December 31, 1988 and 1987, aggregate cost and market value of noncurrent marketable securities are as follows:

	1988	1987
Aggregate cost	$1,145,370	$1,285,730
Aggregate market value	1,083,386	1,242,127

At December 31, 1988, there were $61,984 of unrealized losses and no unrealized gains on marketable securities. At December 31, 1987, there were $43,603 of unrealized losses and no unrealized gains on marketable securities.

At December 31, 1988 and 1987, $1,006,196 and $906,702, respectively, of these securities have been earmarked for designated purposes (see Note 3).

3. **Funds Earmarked for Designated Purposes:**

As of December 31, 1988 and 1987, the Council of the Association had authorized funds to be earmarked for designated purposes. The funds represent noncurrent marketable securities that have been designated for the following purposes as of December 31:

	1988	1987
Capital Asset Improvements and Replacement	$ 316,240	$281,394
Data Processing Improvements and Replacement	450,761	401,094
Malpractice Research	686	9,944
Staff Development	123,196	109,621
Legislative Action	115,313	104,649
	$1,006,196	$906,702

4. **Physicians Insurance Company of Ohio and Subsidiaries:**

The Association owns 100% of the Class B common stock of Physicians Insurance Company of Ohio (PICO). PICO has two classes of common stock, Class A and Class B. Each class of stock has equal rights on a per share basis to participate in dividends and other types of distributions. Each Class A share is entitled to one vote, and each Class B share is entitled to 100 votes.

By virtue of its ownership of 100% of the outstanding Class B shares (36,000 shares), the Association is entitled to 3,600,000 votes. At December 31, 1988, the Class A shareholders owned 3,043,718 shares of Class A stock. Accordingly, at December 31, 1988, the Association was entitled to exercise 54.19% of the voting power of PICO. If the total authorized Class A shares (8,000,000) and Class B shares (66,668) were to be sold, the Class B shareholders would hold approximately 45% of the voting control over PICO.

The Association has recorded its investment in PICO at cost instead of under the equity method since, although owning a controlling interest in PICO, the Association does not share significantly in PICO's earnings.

PICO is limited to selling medical liability insurance only to members of the Association. PICO wishes to encourage medical students to join the Association, hopefully leading to future insurance business for PICO. As a result, the Association and PICO entered into an agreement whereby PICO agreed to reimburse the Association for direct and indirect costs of promoting organized medicine, including the promotion and servicing of new student and resident memberships in the Association. Total reimbursements for the national, state and county medical society membership dues of medical students and residents, including reimbursement for costs incurred in

promoting and servicing the student and resident memberships, were $400,000 in 1988 and $451,911 in 1987. The Association's portion of such reimbursements was $173,729 and $216,760 in 1988 and 1987, respectively, and is included in membership dues in the statement of revenue and expenses.

5. **Sale of Buildings and Land:**
The Association previously leased office facilities and equipment to PICO (Note 4) under terms of an operating lease agreement. In connection with the lease, the Association incurred a loss of $34,738 for the period January through March 1988, and a loss of $53,264 for the year ended December 31, 1987. PICO exercised its option, under such agreement to purchase the office facilities and equipment effective in March 1988. The sale proceeds, approximating $2,388,000, were used to retire the mortgage loan outstanding on the property. The Association recognized a gain approximating $489,000 on such transaction.

In October 1988, the Association sold land and building (including land held by a wholly-owned unconsolidated subsidiary) that it previously utilized for office facilities for a sales price of $1,300,000. In connection with the sale, the Association recognized a gain approximating $388,000.

6. **Leases:**
The Association entered into a seven-year lease agreement for new office facilities commencing August 1, 1988. Under the terms of the lease agreement, the Association must make monthly lease payments of $24,052 plus a proportionate share of building operating costs. In addition to the basic lease agreement, the Association entered into an agreement that allows it to share in 40% of the net cash flow from the building and includes an option to buy the building at a specified price before July 1991.

Additionally, the Association leases automobiles and certain office equipment for terms of up to five years. Minimum annual rental commitments under noncancelable leases as of December 31, 1988 are as follows:

	Capital Leases	Operating Leases
1989	$ 52,570	$ 92,732
1990	45,276	73,251
1991	33,000	22,975
1992	33,000	16,429
Total minimum lease payments	163,846	$205,387
Less amount representing interest	33,608	
Present value of minimum lease payments	$130,238	

Property under capital leases included in property and equipment at December 31, is as follows:

	1988	1987
Data processing equipment	$125,435	
Furniture, fixtures and office equipment	33,266	33,266
	158,701	33,266
Less accumulated amortization	(38,916)	(2,740)
	$119,785	$30,526

Rental expense for 1988 and 1987 was $208,609 and $108,633, respectively.

7. **Pension Plan:**
The Association maintains a trusteed noncontributory defined benefit pension plan for its eligible employees. The actuarial cost method used in determining the valuation of funding is the entry-age-normal with frozen-initial-liability method. The trustee of the plan is American Physicians Life Insurance Company, a subsidiary of PICO and a related party to the Association.

The total cost of the plan charged to operations in 1988 and 1987 was $145,319 and $140,531, respectively, which includes amortization of past service costs over approximately a 30-year period.
A comparison of the accumulated plan benefits and net assets available for benefits for the plan years beginning December 31, is as follows:

	1988	1987
Actuarial present value of accumulated plan benefits:		
Vested	$1,274,247	$1,168,448
Nonvested	86,450	92,843
Total	$1,360,697	$1,261,291
Market value of plan assets available for benefits	$1,698,461	$1,617,011

The assumed investment rate of return used in determining the actuarial present value of accumulated plan benefits was 8%.

8. **Postretirement Benefits:**
In addition to providing pension benefits, the Association provides certain health-care benefits for retired employees. All of the Association's employees may become eligible for those benefits if they reach normal retirement age while still working for the Association. The Association recognizes the cost of providing those benefits by expensing the insurance premiums which were $18,636 and $16,258 for 1988 and 1987, respectively.

9. **Ohio State Medical Journal:**
The income and expenses applicable to the operations of *Ohio State Medical Journal,* for the year ended December 31, 1988, are:

Income:

Advertising (net of commissions and cash discounts of $54,590)	$211,862
Outside subscriptions and other income	360
	212,222

Expenses:

Salaries, pension costs, payroll taxes and other employee benefits	128,612
Printing, postage, stationery, supplies, illustrations, engravings and consulting services	257,455
Building expenses, depreciation and other	118,885
	504,952
Excess of expenses over income, *Ohio State Medical Journal*	$(292,730)

To the extent that the Journal has excess expenses such expenses are subsidized by membership dues.

DEPARTMENTAL OPERATING EXPENSES
for the year ended December 31, 1988
(with comparative totals for 1987)

	Administration	Education and Meeting Management	Specialty Societies	Health Education	Membership	Government Relations
Salaries and benefits	$319,020	$148,706	$ 88,434	$108,942	$152,687	$ 90,002
Staff development	8,588				99	
Pension costs	19,464	10,172	13,079	7,266	11,626	5,813
Staff expenses	36,574	7,371	2,780	6,219	7,873	3,305
President expense and honorarium	14,973					
President-Elect expense and honorarium	10,194					
Past-President honorarium	4,000					
Secretary-Treasurer honorarium	5,000					
Council expense	74,641					
AMA delegate and alternates' expense						
Committees' expense		95,657		16,625	4,294	2,068
Annual meeting		188,960				
Building expenses	26,763	21,642	5,229	7,104	9,417	5,121
Depreciation and amortization	12,694	10,265	2,430	3,370	4,467	2,430
Car lease expense	19,501	5,835	2,140	3,889	3,201	3,309
Councilor district conferences	16,808					
Data processing	780	758	195	207	(8,706)	651
Equipment rental	10,427	8,599	(1,563)	2,869	4,333	2,038
Emergency Fund	26,556	3,870	4,510	226	8,010	157
Doubtful accounts						
Insurance and bonding	9,725	4,512	911	2,097	2,408	1,776
Interest expense	5,583	3,179	753	1,043	1,383	753
Legal expense						
Legislative action						
Library	2,139	788		43	36	1,506
Meeting expense	393			7,091		550
OSMAgram						
Journal printing and postage						
Journal advertising						
Postage	4,998	2,607	3,490	2,514	18,564	2,766
Professional relations	3,202	612	145	201	266	345
Public relations						
Rent	18,631	15,066	3,565	4,945	6,555	3,565
Supplies, miscellaneous	3,604	2,435	1,789	1,008	1,480	1,197
Supplies, office	10,858	7,466	4,128	1,988	14,090	5,067
Taxes, payroll and other	13,965	13,248	6,814	7,315	10,605	6,481
Telephone and telegraph	9,827	7,931	1,648	2,608	1,552	1,880
Totals	$688,908	$559,679	$140,477	$187,570	$254,240	$140,780

Communi-cations	Development and Member Services	State Legislation	Legal Services	Finance	EDP	1988 Totals	1987 Totals
$234,339	$127,003	$264,824	$121,219	$134,162	$ 87,551	$1,876,889	$1,777,344
				6,574	1,180	16,441	39,435
17,438	10,172	20,345	14,532	8,719	7,266	145,892	140,532
13,343	6,468	72,335	12,474			168,742	174,523
						14,973	18,376
						10,194	7,341
						4,000	4,000
						5,000	5,000
						74,641	82,479
	95,840					95,840	98,017
1,092	341	9,532	15,691	64,521		209,821	166,357
						188,960	219,689
31,389	11,399	18,999	11,564	(7,778)	6,608	147,457	93,521
14,888	5,407	9,011	5,486	4,780	3,134	78,362	37,188
3,007	3,288	6,505				50,675	66,563
						16,808	6,067
1,228	332	914	405	3,716	35,884	36,364	43,175
13,070	4,610	7,582	4,958	5,050	2,508	64,481	67,170
1,671	433	5,791	2,041	14,827	103	68,195	40,745
14,092						14,092	4,057
6,188	2,785	4,957	1,969	1,716	1,125	40,169	34,176
4,410	1,675	2,792	1,698	897	971	25,137	7,683
	10,503	3,166	82,461			96,130	41,626
		1,002				1,002	52,132
1,023	289	4,040	2,439	523	90	12,916	15,247
		23				8,057	9,447
59,420						59,420	54,390
256,859						256,859	222,606
596						596	5,411
13,764	4,238	6,648	4,194	661		64,444	58,370
887	322	737	327	285	187	7,516	9,680
58,613						58,613	115,304
21,851	7,935	13,226	8,050	7,015	4,600	115,004	
4,459	1,833	2,264	1,531	1,888	1,254	24,742	9,429
20,120	3,062	24,342	3,239	3,776	2,083	100,219	69,403
18,219	7,908	17,890	9,728	10,010	6,276	128,459	143,311
12,781	4,186	6,976	4,246	3,700	2,426	59,761	67,428
$824,747	$310,029	$503,901	$308,252	$265,042	$163,246	$4,346,871	$4,007,222

ASYMPTOMATIC CHLAMYDIA INFECTION IN PREGNANT WOMEN

Michael T. Hagley, MD
Anthony J. Costa, MD

Chlamydia trachomatis infection is currently among the most prevalent sexually transmitted diseases in the United States. A review of three textbooks of obstetrics reveals that none of them recommend routine chlamydia screening in prenatal patients, although two recommend routine screening for gonorrhea. A study was done at the Barberton Citizens Hospital Family Practice Residency Program to determine the incidence of asymptomatic chlamydia infection in pregnant women and to compare this to the incidence of asymptomatic Neisseria gonorrhoeae infection in the same population. A total of 69 patients were screened for Neisseria gonorrhoeae and Chlamydia trachomatis as part of their routine prenatal evaluations at the first prenatal visit and the visit of 36 weeks gestation. Neisseria gonorrhoeae was detected by growth on standard Martin-Lewis culture plates. Chlamydia trachomatis was detected by positive immunofluorescence using a standardized specimen kit (Syva Company, Palo Alto, California). The data were collected over a 12-month period from July of 1987 through July of 1988. There were no positive cultures for Neisseria gonorrhoeae (0%) in this group of patients. On the other hand, five patients tested positive for Chlamydia trachomatis (7.2%). The results of this study indicate that routine screening for Chlamydia trachomatis should be considered as part of the routine prenatal care. A larger, multicentered study could be done in the future to confirm these results, as well as to determine if any regional differences exist.

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Introduction

Infection with *Chlamydia trachomatis* is among the most commonly occurring sexually transmitted diseases.[1] *Chlamydia trachomatis* has been isolated from the endocervix of between 7% and 18% of asymptomatic pregnant women, and it is more prevalent than *Neisseria gonorrhoeae* among women presenting to sexually transmitted disease clinics.[2] Nevertheless, while two out of three standard obstetrics textbooks recommend routine prenatal testing for *Neisseria gonorrhoeae*[3,4] none recommend routine testing for *Chlamydia trachomatis.*[3,4,5]

Delivery of an infant in the presence of cervical chlamydial infection carries risks for the mother and the neonate. Maternal risks include development of salpingitis, future ectopic pregnancies, infertility and postpartum endometritis.[2] Risks to the infant include increased incidence of conjunctivitis,[6] pneumonia,[6] asymtomatic colonization of the nasopharynx and gastrointestinal tract,[2] perhaps perinatal mortality,[7] otitis media[7] and preterm rupture of membranes.[8]

Cervicitis due to *Chlamydia trachomatis* can be treated in pregnancy using erythromycin,[7] and treatment has the potential to improve outcome and reduce morbidity associated with chlamydial infections in pregnancy.

At our institution we conducted a study of asympto-

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matic pregnant women who presented for routine prenatal care and compared the incidence of *Chlamydia trachomatis* infection to the incidence of *Neisseria gonorrhoeae* infection.

Materials and Methods

All patients who met the criteria for our study during a one-year period from July of 1987 to July of 1988 were enrolled. The criteria for enrollment were: 1) proven pregnancy and 2) absence of symptoms of cervicitis or pelvic inflammatory disease. Sixty-nine consecutive patients were enrolled, and no patients were excluded by the above criteria.

During the initial visit, samples were obtained to detect the presence of *Chlamydia trachomatis* and *Neisseria gonorrhoeae.* At 36 weeks estimated gestational age, additional samples were obtained from 52 of the 69 patients enrolled. Factors responsible for failure to obtain a sample at 36 weeks in the 17 remaining patients include premature delivery, spontaneous abortion, referral to a high-risk obstetrics center, geographic relocation of the patient and physician error.

Samples were obtained by placing a sterile dacron swab in the endocervical canal and rotating the swab for 5-10 seconds. *Neisseria gonorrhoeae* was detected by growth on standard Martin-Lewis culture plates. *Chlamydia trachomatis* was detected by positive immunofluorescence using a standard specimen kit (Syva Company, Palo Alto, California). This test has a sensitivity of 92% and specificity of 98% compared to primary culture. Martin-Lewis culture plates were examined for growth by registered nurses in our clinic 48 hours after specimens were obtained. Chlamydia specimen kits were interpreted by our hospital laboratory.

Patients who tested positive for *Chlamydia trachomatis* were treated with erythromycin base, 500 mg by mouth four times per day for seven days in accordance with the recommendations of the Centers for Disease Control.[9]

Retrospective review of charts were done to define some of the characteristics of our sample. Information obtained included maternal age at first appointment, estimated gestational age at first appointment, total number of pregnancies, billing status, marital status and race. Average patient age and number of previous pregnancies were compared between chlamydia-positive and chlamydia-negative patients using an undirectional Student's T-test. The estimated gestational age was compared using a bi-directional Student's T-test.

Results

No positive cultures for *Neisseria gonorrhoeae* were obtained. Five patients out of 69 (7.2%, 95% confidence interval 4.1% to 10.3%) had positive immunofluorescence tests for *Chlamydia trachomatis.* Four of these positive tests were obtained during the initial visit, and one was obtained during the 36-week visit on a patient who had a normal test at her initial visit.

The characteristics of the population we studied are summarized in Tables 1 and 2. Patients' ages ranged from 13 years to 43 years with a mean of 23.2 ± 5.5 years. Patients who tested positive for *Chlamydia trachomatis* were younger, on average, than patients who tested negative (mean ± standard deviation 19.2 ± 2.7 vs. 23.4 ± 5.6 years, $p < 0.05$), presented at an earlier gestational age (9.4 ± 2.6 vs. 15.6 ± 7.1 weeks, $p < 0.10$), and had a lower gravida (1.2 ± 0.44 vs. 2.5 ± 1.6, $p < 0.05$).

Of the patients who did not have *Chlamydia trachomatis* infection, 38 were on government relief, 24 were private pay and two belonged to a health maintenance organization. Twenty were married, 26 were single and eight were divorced. Sixty were white and four were black.

Of the patients who did have *Chlamydia trachomatis* infection, all were on government relief and all were single. Four of these patients were white and one was black.

TABLE I

Age of patient, gestational age of fetus, and total number of pregnancies as they relate to presence or absence of *Chlamydia trachomatis* infection.

Group	Age (Years)	Gestational Age (Weeks)	Gravida
Chlamydia-negative	23.4±5.6	15.6±7.1	2.5±1.6
Chlamydia-positive	19.2±1.7	9.4±2.6	1.2±0.44
All patients	23.1±5.5	15.0±7.1	2.4±1.6

*Values are expressed as mean ± standard deviation. Chlamydia-negative and chlamydia-positive groups are significantly different for all measurements at the 0.05 level.

Discussion

In the population of asymptomatic patients seeking obstetrical care in the clinic operated by our residency program, the prevalance of *Chlamydia trachomatis* cervicitis was 7.2%. The prevalance of *Neisseria gonorrhoeae* was zero. Patients with *Chlamydia trachomatis* were likely to be younger, to present earlier in gestation, and to have fewer prior pregnancies. Our population is lower-middle socioeconomic class, largely white and largely single. An association between chlamydia infection and young age has been demonstrated previously.[9,10,11] Most likely, the low gravida we observed in chlamydia-positive patients reflects the younger age of this group. To our knowledge, early presentation in pregnancy has not been associated with chlamydia infection previously, and we cannot find any reason to expect such an association. It most likely is a random occurrence owing to our small sample size.

As with any routine screening test, it is necessary to determine whether the benefits to be gained justify the cost and risk associated with performing the test. Our study was not designed to specifically answer this question, and the vast number of variables involved would mandate a much larger number of subjects to perform a meaningful cost-benefit analysis. Nevertheless, it is possible to elaborate on the potential medical benefits of routine screening.

Maternal risks associated with *Chlamydia trachomatis* infection include postpartum endometritis,[9] salpingitis, future ectopic pregnancies and future infertility.[2] One series showed that late postpartum endometritis occurred in 19% of patients with and 5% of patients without antepartum chlamydial infection.[9] *Chlamydia trachomatis* has been linked to salpingitis in numerous studies. As compared to gonococcal salpingitis, chlamydial salpingitis is usually less acutely symptomatic, is associated with

TABLE 2

Mode of payment, marital status and race as they relate to presence or absence of *Chlamydia trachomatis* infection.

Group	Mode of Payment			Marital Status			Race	
	GR	P	HMO	M	S	D	W	B
Chlamydia-negative	38	24	2	20	36	8	60	4
Chlamydia-positive	5	0	0	0	5	0	4	1
All patients	43	24	2	20	41	8	64	5

GR = government relief, P = private pay, HMO = health maintenance organization, M = married, S = single, D = divorced, W = white, B = black.

a higher rate of infertility, and requires longer therapy to eradicate the infection.[2] Infants born to mothers with chlamydial infections are at risk for several complications as well. Conjunctivitis is a common complication, with rates of 18%[6] and 33%[10] published. Fortunately, this risk can be minimized by giving prophylactic erythromycin ophthalmic ointment.[10]

Chlamydial pneumonia is reported to occur within the first six months of life in 7%[10] to 16%[6] of infants born to infected mothers, and 33% of infants with asymptomatic nasopharyngeal chlamydial colonization eventually developed chlamydial pneumonia.[10]

Chlamydial cervicitis is associated with preterm rupture of membranes[8] and may be related to an increased perinatal mortality.[7] Asymptomatic colonization of the nasopharynx and gastrointestinal tract occurs in some infants at risk,[2,10] although the significance of this is not clear. Chlamydial otitis media may also be more common in infants born to infected mothers.[2,7]

Since the incidence of many of the risks associated with birth in the presence of chlamydial cervicitis is difficult to determine, the cost of treating these complications is unclear. The cost to the patient of screeening for *Chlamydia trachomatis* using the method we describe is $32 per test. The test has a sensitivity of 92% and specificity of 98%. Thus, in a population with an incidence of 7.2%, the predictive value of a positive test is 78% and the predictive value of a negative test is 99%.

In the absence of a cost-benefit analysis, it is impossible to say whether routine screening is cost-effective. Nevertheless, given the possibility of preventing potential mortality, morbidity and hardship with routine screening, consideration must be given to screening moderate- and high-risk patients. Factors associated with an increased incidence of chlamydial cervicitis include young age,[2,11,12,13] new sexual partner, [11,12,13] use of non-barrier contraception,[12,13] a partner with urethritis,[11] signs of cervical inflammation on examination,[11,12,13] and younger age of first intercourse.[13]

Screening moderate and high-risk patients is consistent with the recommendations of the Centers for Disease Control (CDC) for chlamydial screening in pregnancy. The CDC recommends screening at the first prenatal visit for: 1) adolescents (<20 years of age); 2) unmarried women; 3) married women who may be at high risk because of multiple sexual partners or a history of other STD.[7]

A further question that must be asked is whether screening for *Neisseria gonorrhoeae* is justifiable. In our study, as well as others, *Chlamydia trachomatis* is more prevelant than *Neisseria gonorrhoeae* and is more likely to be asymptomatic. Thus, screening for *Chlamydia trachomatis* is more likely to be beneficial than screening for *Neisseria gonorrhoeae.*

In our study we have compared the incidence of chlamydial cervicits to the incidence of gonorrheal cervicitis in asymptomatic pregnant patients. Chlamydial infections were more common, a finding consistent with other published studies. Delivery through an infected cervix poses risks to both mother and infant, and screening followed by appropriate treatment has the potential to reduce these risks. Thus, we suggest that for many asymptomatic patients who are in moderate- or high-risk groups, screening for *Chlamydia trachomatis* should be considered.

REFERENCES

1. Spalding TR. The role of Chlamydia in sexually transmitted diseases. *Family Practice Currents* 1988; 4:1.
2. Thompson SE and Washington AE. Epidemiology of sexually transmitted *Chlamydia trachomatis* infections. *Epidemiologic Reviews* 1983; 5:96-123.
3. Pritchard JA, MacDonald PC, Grant WF: *Williams Obstetrics* (17th ed), Norwalk; Appleton-Century, Crofts; 1985, p 249.
4. Pernell MC, Benson RC: *Current Obstetric and Gynecologic Diagnosis and Treatment* (6th ed), Norwalk; Appleton and Lange; 1987, p 171.
5. Danforth DN and Scott JR: *Obstetrics and Gynecology* (5th ed); Philadelphia; Lippincott; 1986, p 367.
6. Schafer J, Grossman M, Sweet RL, et al. Prospective study of perinatal transmission of *Chlamydia trachomatis. JAMA* 1986; 225(24):3374-7.
7. Centers for Disease Control. *Chlamydia trachomatis* infections: policy guidelines for prevention and control. *MMWR* 1985; 34(suppl 3):53-745.
8. Alger LS, Lovchik JC, Hebel JR, et al. The association of *Chlamydia trachomatis, Neisseria gonorrhoeae,* and group B streptococci with preterm rupture of the membranes and pregnancy outcome. *American Journal of Obstetrics and Gynecology* 1988; 159:397-404.
9. Wager GP, Martin DH, Koutsky L, et al. Puerperal infectious morbidity: Relationship to route of delivery and to antepartum *Chlamydia trachomatis* infection. *American Journal of Obstetrics and Gynecology* 1980; 138:1029-33.
10. Hammerschlag MR, Chandler JW, Alexander ER, et al Longitudinal studies on chlamydial infections in the first year of life. *Pediatric Infectious Disease* 1982; 1(6):395-401.
11. Addiss DC, Vaughn ML, Holzhueter MA et al. Selective screening for *Chlamydia trachomatis* infection in non-urban family planning clinics in Wisconsin. *Family Planning Perspectives* 1987; 19(6):252-6.
12. Handsfield HH, Jasman LL, Roberts PL, et al. Criteria for selective screening for *Chlamydia trachomatis* infection in women attending family planning clinics. *JAMA* 1986; 255(13):1730-34.
13. Shafer M, Beck A, Blain B, et al. *Chlamydia trachomatis:* Important relationships to race, contraception, lower genital tract infection, and Papanicolaou smear. *The Journal of Pediatrics* 1984; 104:141-6.

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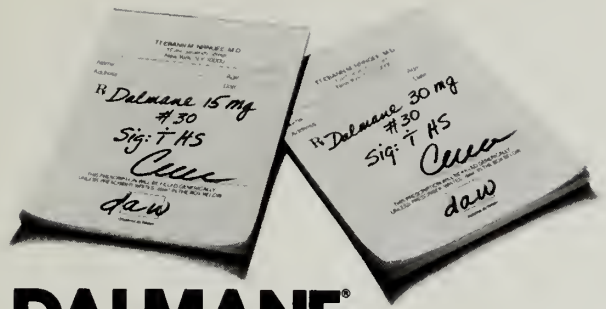
AMA Report

• **AMA membership increase** . . . The AMA Division of Membership reports that its year-end data for 1988 show growth in the AMA's market share of women physicians and physicians younger than 45. The AMA's market share of female MDs has increased steadily in this decade, from 25.2% in 1980 to 30.5% in 1988, while the market share among male physicians dropped from 47.1% in 1980 to 45.7% in 1988. Physicians 45 years of age or older are more likely to be AMA members than are younger physicians. However, the market share among older physicians declined from 57.6% in 1980 to 48.3% in 1988, while the market share among younger physicians is increasing steadily from 32.9% in 1980 to 38.5% in 1988.

• **AMA and AIDS** . . . Implementing Centers for Disease Control (CDC) recommendations for preventing HIV transmission in health-care settings is the best strategy for reducing the risk of occupational transmission of blood-borne diseases, the AMA said in its comments on the Occupational Safety and Health Administration's proposed rule on occupational exposure to blood-borne pathogens. The AMA stressed that the CDC recommendations are widely known throughout the health-care sector, have been readily accepted by other regulatory authorities, and will continue to be modified as scientific knowledge and infection control technology advances. The AMA suggested several modifications to the proposed rule's new standard for regulating occupational exposure to blood-borne pathogens and asked that the risk of blood-borne infections be kept in perspective in relation to other workplace hazards so that the public does not become misleadingly alarmed about transmission of HIV.

• **Assuring health-care quality** . . . The *QA Review,* a newsletter published by the AMA's Office of Quality Assurance, will be printed 10 times a year to provide an open line of communication with professionals in the field throughout the United States. Each issue will feature columns called "Professionals' Corner" and "Viewpoint." In "Professionals' Corner," *QA Review* will ask a physician, quality assurance director or other qualified professional to draw upon his or her personal experience and describe how a specific quality assurance problem was confronted and successfully resolved. Subscriptions are $40 a year for members, $75 for non-members. To subscribe, call (800) 621-8335.

• **Doctor to Youth** . . . In its first year of operation, the AMA's Youth HIV Education Project, a five-year project funded by the Centers for Disease Control Division of Adolescent and School Health, had 34 physicians and four medical society executives working in 35 different areas across the country. The group volunteered its time to support AIDS education for adolescents in schools through a variety of activities. In addition, it has begun publishing a newsletter every other month for participants and members of the educational community with up-to-date information about adolescents and HIV.
"Last year we worked in 27 states, with one person serving each area," says Missy Fleming, program administrator. "In the second year we will be moving from individual locations to statewide efforts. We hope to be working in about eight states, including Mississippi, Illinois and Ohio, with 25 or more people serving each state." Physicians interested in participating in the project can call Fleming at (312) 645-5315.



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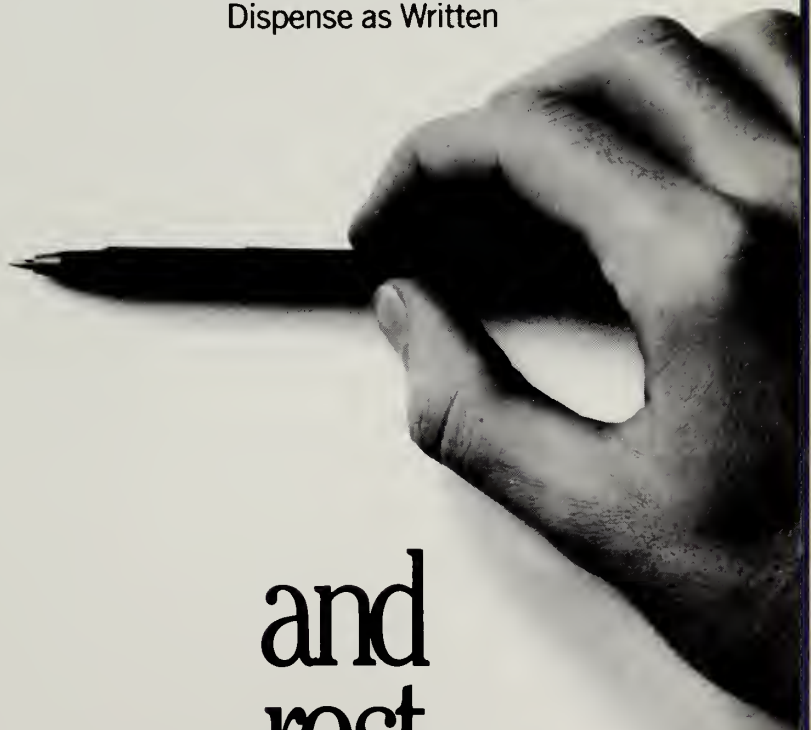

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References: 1. Kales JD, *et al: Clin Pharmacol Ther 12* 691-697, Jul-Aug 1971 **2.** Kales A, *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A, *et al: Clin Pharmacol Ther 19*:574-583, May 1976. **4.** Kales A, *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Dement WC, *et al: Behav Med 5*: 25-31, Oct 1978. **7.** Kales A, Kales JD: *J Clin Psychopharmacol 3*:140-150, Apr 1983. **8.** Tennont FS, *et al:* Symposium on the Treatment of Sleep Disorders, teleconference, Oct 16, 1984 **9.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977.

Before prescribing, please consult complete product information, a summary of which follows:

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CONTRAINDICATIONS: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

WARNINGS: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

PRECAUTIONS: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function. Inform patients to consult physician before increasing dose or abruptly discontinuing flurazepam HCl.

ADVERSE REACTIONS: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

DRUG ABUSE AND DEPENDENCE: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

DOSAGE: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

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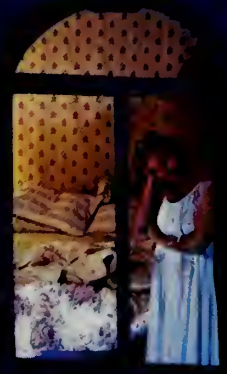

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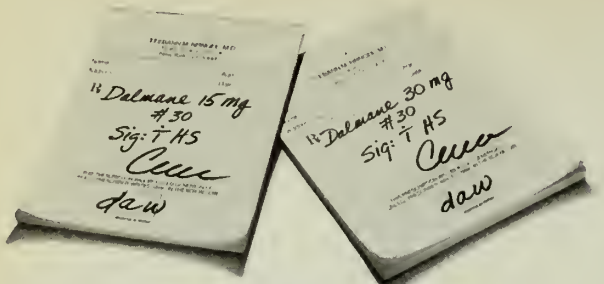

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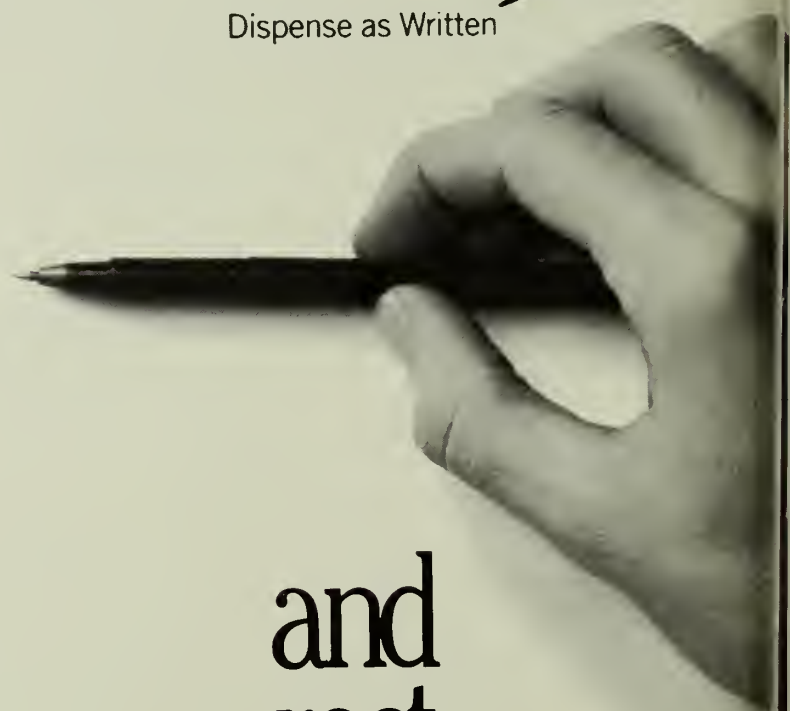

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"Astra"

By Marianne Pich-Nissen

A star, or rather a starry cluster, floats in the center of the Trumbull Memorial Hospital lobby. Colors and shapes and lines radiate energy and light. "Astra" is the creation of the nationally known Cleveland sculptor John Clague. He gives us his very own artistic expression of a symbol, a symbol of spirit, hope and endurance. The idea that life will brighten again when the crisis of the moment passes is a comforting concept for all who experience anxiety.

"Ad astra per apsera" says a classical Latin proverb: "Through hardship to the stars."

In contemplation of the artwork, each individual will find his or her own special meaning. The 14-foot, four-inch-high piece consists of a diamond surrounded by four wings. Its configuration is a response to the architecture of the lobby. The angle of its radiating planes is an echo of the skylight structure. Reflecting the contemporary components of its environment, "Astra" achieves a "built-in" appearance.

The sculpture by John Clague, whose art can be seen in the Cleveland Museum as well as in numerous museums throughout the country, was donated to the hospital by Covelli Enterprises, 1988. **OSMA**

Marianne Pich-Nissen is a member of the OSMA's Art and Culture Committee, and has coordinated the assembly of artworks on exhibit at Trumbull Memorial Hospital. For further information about Trumbull's exciting arts program, read Pich-Nissen's article in this month's "Ohio Medi-scene" section.

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1989 Subscription: $25 per year.

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FROM THE EDITOR

Statehouse Monitors

Much of what the Ohio State Medical Association does takes place not in the field of medicine, but in the field of legislation. Each year, as more and more groups propose bills that directly affect the delivery of health care in our state, OSMA's Legislative Department, headed by John Van Doorn, spends countless hours at the Statehouse, seeing to it that the voice of OSMA physicians doesn't become lost in the legislative process.

They carefully study each health-care bill that's introduced and monitor its progress through endless rounds of committee hearings and floor debates. They lobby . . . they testify . . . and, more often than not, they're successful in their attempts to hammer out legislation that most physicians can live with. In legislative circles, that's accomplishment indeed.

This month, our legislative staff has provided us with a status report of pending health-care legislation. Read it, study it, and if there is an issue there about which *you* feel strongly, let our legislative department know. They can put you in touch with those members of the House or Senate who are listening . . . and need to know how you feel.

Also in this issue, we've included a study, done by the Ohio Department of Health this past June, on Ohio's physicians' attitudes toward AIDS. It's a revealing and rather surprising look at how the state's medical profession is dealing with the so-called "AIDS epidemic." Take a look at it and see how your own attitudes toward treating AIDS patients measure up.

Is there anything new in the area of reproductive technology that we failed to cover in our series on the subject in March, 1988? Surprisingly, yes. This field continues to grow and develop as quickly as research and technology allow. In this month's "Ohio Medi-scene" section, you'll find an article featuring the latest news on this subject.

Also note that we have a new associate editor on board — Karen Kirk. Kirk comes to the OSMA and *OHIO Medicine* from the Columbus Cancer Clinic — and with 15 years of writing experience behind her (including a stint as a feature editor at the *Columbus Dispatch*). We think you'll find her direct style an asset to your publication.

Next month, however, we hope to give you an opportunity to tell us what you do and don't like about your publication. Look for the Readership Survey in the January issue of *OHIO Medicine* . . . and please take some time to fill it out. We would really like to hear from you . . .

Also next month, the OSMA will begin its new gender-neutral policy. Carol Mullinax, OSMA's Director of Communications, has written an informative article about our new policy in the "Ohio

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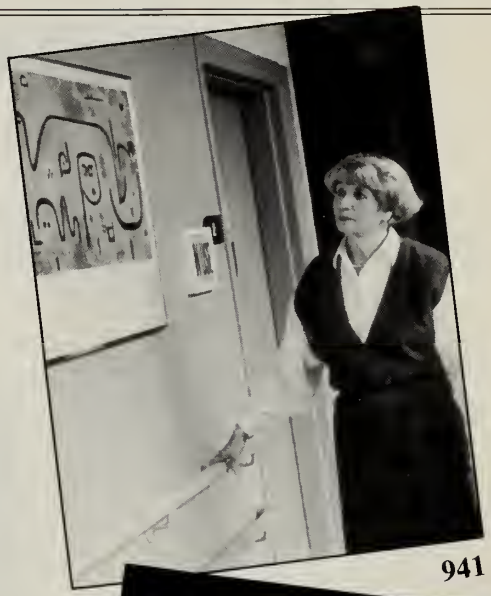

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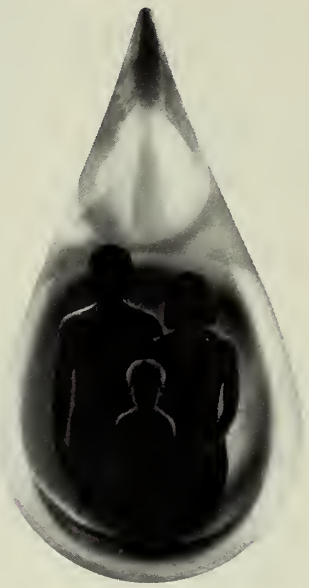

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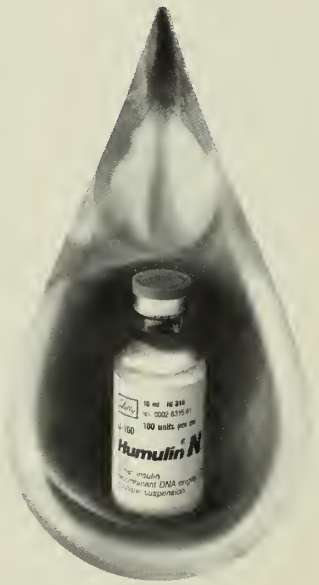

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Impressions

By William J. Marshall, MD
President of the OSMA

In October I attended the 1989 AMA National Political Education Conference in Washington, D.C. along with approximately 40 Ohio physicians and spouses, the largest delegation in attendance. The title of the conference was "Preventive Politics: Preparing for the 1990s." During a busy two days in our nation's capital, I attended the Dr. Nathan Davis Awards Banquet, visited with some of my elected representatives and their staffs, heard a number of lectures and a few partisan speeches. This visit left me with an assortment of impressions that I would like to share with you in the context of this paper.

This year was the first for the Dr. Nathan Davis Awards, presented by the AMA to recognize outstanding contributions by public servants "to promote the arts and science of medicine and the betterment of the public health." The following were recognized at the awards dinner, which Barbara and I attended:

- C. Everett Koop, Immediate Past U.S. Surgeon General, who elevated the concept of public health to unprecedented heights during his tenure while tenaciously fending off political challenges to his public health strategies. Award category: Member of the Executive Branch serving through presidential appointment.
- Lowell Weicker, former U.S. Republican senator from Connecticut, who currently is CEO of Research America, for his Senate leadership in advancing the cause of medical research through higher funding levels and in programs to protect and assist the handicapped. Award category: U.S. senator.
- Rep. Henry Waxman (D-CA), for exerting his influence as a national political leader in furthering legislation to protect and expand public health. Award category: U.S. representative.
- Donald A.B. Lindberg, MD, director of the National Library of Medicine, for his contributions in advancing the stature and effectiveness of that institution. Award category: Member of the Executive Branch in career public service.
- W. Donald Schaefer, governor of Maryland, for his foresight and initiative in catalyzing development of a dynamic program educating both the young and the old on how to ameliorate the drug crisis. Award category: governor.
- Ann Wynia, former Minnesota state representative and current commissioner of the Minnesota Department of Human Services, for her leadership in addressing state health needs through innovative approaches. Award category: State legislator
- Vincent C. Schoemehl, mayor of St. Louis, and Gene McNary, St. Louis County government executive, for their creativity in developing a communitywide health program covering both political constituencies and meeting health needs through combined utilization of public and private institutions.

To kick off the conference, Senator Alan K. Simpson (R-WY), Assistant Minority Leader, U.S. Senate, spoke on the current state of affairs in Congress. He had some wonderful one-liners! Speaking of a citizen's participation in government, "You either take part or get taken apart." In reference to lobbyists and their tactics, "Lobbying has become an art form in Washington, D.C." In expressing his concern about the Social

Security shortfall by 2030, "What can you expect when you get three bucks back for every buck put in?" Lastly, in reference to heavy lobbying by senior citizens against the catastrophic health-care bill, "I got the nastiest mail from the richest people . . . Some of those folks are as tough as a boiled owl."

During our brief stay in Washington, prior arrangements had been made to meet with some of our elected representatives and/or staff. We met with staff in the offices of Sens. Glenn and Metzenbaum and congressman Willis D. Gradison, Jr. We were able to meet personally with congressmen Paul E. Gillmor, Michael DeWine and Tony Hall. In each office we were warmly received and spent 30-60 minutes in discussion about health matters that impact on patients and physicians. I left each office satisfied that the elected representative had a better understanding of the complex medical issues that they would eventually debate and vote upon. I came away from these discussions with President Eisenhower's admonition seeming truer than ever, "Politics ought to be the part-time profession of every citizen."

Since 1981, Congress each year seems to face the equivalent of football's two-minute drill when it faces the so-called reconciliation bill, whose official purpose is to cut the budget deficit. From the beginning Congress practices sleight of hand with the process, which has resulted in railroading into law literally hundreds of programs that could not pass Congress on their own merits. This year is no exception, and unfortunately, reconciliation is where all the bills that will affect medicine are floating. The reconciliation bill also contains the seeds for significant increases in federal spending down the road. At first glance, they seem so innocent — as if the batteries in your calculator have gone dead. A rather small $188 million expansion of Medicaid in its first year grows steadily to $4.2 billion during the next five years. In another example, one of the two competing child-care programs approved as part of the bill would cost $200 million the first year, but expands its cost to $4.6 billion in fiscal 1994, for a total five-year cost of $14 billion. The bill relies on magic (also called accounting devices) to create the illusion of meeting the deficit reduction targets of the Gramm-Rudman-Hollins Law. The bill also contains numerous extraneous and sweeping changes in laws that have nothing to do with cutting the deficit. Beryl Anthony, Jr. (D-AR) said, "If you've got a needle to hide, that's the haystack." As we took leave of Washington, the House passed this 1,935-page bill full of budgetary gimmickry. Next, it's on to the Senate, and the question is, can that body resist the schemes to which the House has fallen prey?

Meanwhile back at the meeting, participants were learning coalition building: a "how-to" session. This is one of the areas in which I have felt physicians and organized medicine must look as we attempt to garner change. We can't go it alone! As one legislator said during the meeting, "The AMA is heard, but Congress' response is often muted." Once a cause is agreed upon, we should look to those whose needs overlap ours and join hands in a common effort to form a partisan base.

In the waning moments of this meeting, we were treated to some heavyweights in the areas of political advertising and communications. They took examples from recent presidential and congressional races and demonstrated with tape bites the structuring of political advertisements and the messages they were meant to deliver. I came away feeling they play very rough. In our professional jargon, they go for the jugular.

At the very end of the meeting, the conference was addressed by the respective heads of each political party. Lee Atwater, chairman, Republican National Committee, spoke of his role in candidate selection and political race strategies. Ron Brown, chairman, Democratic National Committee, talked about his party's ability to control the House and Senate and the party's inability to capture the presidency. One got the distinct feeling that both of these men wanted much more from their respective parties.

Well, having said all this, what are my impressions? This is a representative government. You and I have an opportunity, both as a representative of the medical community and as a citizen, to establish continuous effective communications with our legislators. Our contacts can have an impact on the outcome of certain bills of importance to our profession and to each of us personally. These contacts will have their greatest impact if a personal relationship exists between each of us and our elected officials and their staffs.

And now I ask your indulgence as I request a moment of personal privilege. As we enjoy the month of December and look forward to the new year, Barbara and I would like to wish each of you a happy holiday season and a happy, healthy New Year. **OSMA**

Conference Roundup

By Barbara Marshall
President of the OSMA-A

Barbara Marshall
OSMA Auxiliary President

Opportunities abound for OSMA Auxiliary members to expand their horizons. The fall months have offered a plethora of avenues to develop leadership skills, discuss strategy to address crucial health issues, and gain personal enrichment. Our county auxiliaries have had a wide menu from which to choose.

For nearly 15 years, state and county auxiliary leaders from across the country have taken part in Leadership Confluence, offered by the AMA Auxiliary. State and county presidents-elect gathered at the Drake Hotel in Chicago September 24-26 to learn from experts in various fields and from fellow auxiliary members how to conduct successful programs and projects and how to be more effective auxiliary leaders. Ohio counties represented by their presidents-elect were Clark, Hamilton, Lawrence, Lucas, Montgomery, Scioto and Summit.

Consultation sessions dealt with organizational matters such as programming, building membership by working with target markets, and team efforts of medical societies and auxiliaries. Training for more specific skills were offered in sessions on leadership development and organization management, publication of newsletters, and parliamentary procedure.

At a plenary session, Dr. Carolyn Desjardins, director of the National Institute for Leadership Development, spoke of the differences in leadership styles. That of the male is typically based on justice and rights, while the style of women is often centered on relationships and care. This has a bearing on learning style and interaction with others.

Sessions on health-related topics were invaluable to those leaders who will plan service projects for their auxiliaries. In keeping with the emphasis on adolescent health, subjects covered were parenting, HIV/AIDS education for youth, the health of adolescents, and comprehensive school health education.

The AMA Auxiliary offers Professional Skills Development (PSD) credit for each session attended during the Confluence. This provides a central source of documentation of members' participation in instructional courses and training programs that develop new or enhance current business or professional skills. Thus, an auxilian may develop a resume that might prove quite useful in the future.

One of the most valuable and popular features of the Confluence was the exhibit area where state and county auxiliaries shared their projects, large and small. Also on display were the many materials, publications and videos that the AMA Auxiliary has developed for use by state and county auxiliaries.

The 3,700 participants from past Confluences agree that this is the finest leadership training available. The benefits are felt far beyond the medical community.

Closer to home, the OSMA Auxiliary offered its own Confluence to members on October 13. Seventy auxilians came together at Wright State University School of Medicine to explore a most contemporary topic — "The Middle Years: The Sandwich Generation." Attention was focused on this large group, which has the responsibility of caring for children on the one hand and for aging parents on the other.

Sherry Stanley, MD, breathed warmth and compassion into demographics as she spoke of caring, not "curing," and described a 93-year-old patient

OSMA Auxiliary members attending the "Age of Choice" seminar were: (l. to r.) seated, Evan Vallassiades, Joyce Penn, Carol Wenger (Executive Director, OSMA-A), Doris Albernaz, Judith Carrigan, Mary Ann Sotckum. Standing, Paula Parker, Sally Pap, Marita Tulisiak, Barbara Marshall, Sue Massie.

Patricia Ellis, Ohio Youth Services Network, stands with the OSMA-A sign announcing the group's workshop at the "Age of Choice" seminar.

Auxiliary members attending the AMA Leadership Confluence this past autumn in Chicago were: (l. to r.), seated, Sue Massie, Barbara Marshall, Judy Robinson. Standing, Julia Bhattacharyya, Shirley Rundell, Cheryl Duffy, Grace Martin, Denise Kneisley, Carol Wenger (Executive Director, OSMA-A) and Dolores Feldheimer.

with a zest for life. Robert D. Reece led a thoughtful discussion on morality and the law. How should society deal with certain ethical issues? "A Powerful Political Force," guided by James Jacob, explored issues such as insurance, access and care for the elderly.

The keynote speaker was Donna T. Pepe, vice president of the public sector for corporate Johnson & Johnson. This bright, attractive young woman is a pioneer in the field of marketing for pharmaceuticals. She spoke of the social impact of "the pill" and of her company's activities in the area of patient communication and education. "Straight Talk," a sex education module developed by them, is taught in 5,500 high schools and will be joined shortly by an AIDS unit.

"The 3,700 participants from past Confluences agree this is the finest leadership training anywhere . . ."

Positive attitudes and healthy life-styles were the subject of a group session led by Judith Tangeman, MD, while the workshop facilitated by Marilyn Kaplan discussed self affirmation and choices. The final plenary session was conducted by Elaine Koenigsberg. In discussing sexuality she dealt with challenges confronting people at mid-life.

At the close of this stimulating, thought-provoking conference, auxilians came away with increased understanding, a few answers, and many challenges. **OSMA**

OSMA and OSMA-A Help in "Rescuing the Future" For Youth

When the "Age of Choice: Rescuing the Future" seminar was held in September in Columbus, the OSMA's and OSMA-A's presence was acknowledged as Barbara Marshall, OSMA-A president, introduced the teen pregnancy workshop, sponsored by both organizations.

Marvelous! Terrific! Wonderful! Great! Enlightening! These are the superlatives used to describe the youth seminar which included nationally renowned keynote speakers Benjamin J. Primm, MD and Michael Carrera, and 28 workshops divided into issues and challenges, strategies, programs and responses, and empowerment.

"Issues and Challenges" identified mental health issues, AIDS, dysfunctional families, alcoholism and other dysfunctions and children, "Crack Cocaine: The Fleecing of America", teen pregnancy, non-intentional injury, and sex offender programs.

Strategies dealt with a violence prevention curriculum for adolescents, interdisciplinary team approach, stress management, mediation, government entities and legislation, the Cincinnati Youth Commission, and grant writing.

Programs discussed were the Franklin County Pregnancy Prevention Program, the GRADS program, and the Students at Risk Program for Teen Parents, Teens Can Be Stars (Sharing Teen AIDS Resources), Targeting High Risk Youth (ODH), Dayton's New Futures Program, Healthy Moms and Babes, Teen Institute, Invest In Me — I Am The Future, and the 4-H Health Curriculum.

Empowerment covered promoting healthy choices, strengthening families; TeenCAP: An Assault Prevention Project; Crossroads: Affirmation of the African-American Adolescent; Community Organization (Newark); Interactive Videodisc: Innovative Media for Intervention; and Adolescents and Sexually Transmitted Diseases.

The keynote speakers were excellent and their sincerity and dedication were evident. Dr. Primm has joined the President's council on Drug Abuse, and Carrera has actively joined in the battle to rescue the youth of New York. Alfred Tutela, superintendent of the Cleveland Public Schools and the luncheon keynote speaker, affirmed his commitment to helping the youth of Cleveland.

Attendance exceeded 400 and included representatives from all segments of youth agencies and service providers for youth in Ohio. Fourteen members of the OSMA-A were registered as well as Carol Wenger, Executive Director.

Minds were overloaded by the conclusion of the seminar, but all in attendance felt much better prepared to address the issues of youth in their respective communities, and felt that the OSMA and OSMA-A had made a positive contribution to today's education on problems of youth.

— Sue Massie, President-Elect. OSMA-A

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LETTERS TO THE EDITOR

Reducing liability risks

To the Editor:

I was pleased to see the Loss Awareness Bulletin entitled "Reducing the Risk of Liability With the Help of Hospital Staff" in the September, 1989 issue of *OHIO Medicine.* The suggestions listed on page 722 are an outstanding summary of many of the problems that are seen in the Peer Review Organization reviews of medical records. Documentation by the attending physician that the abnormalities seen in the nursing notes have been noticed and addressed, and the overall question of physician interaction with the nursing service are frequent issues that arise in the quality review of the Medicare patient in the PRO system. Using the suggestions that are included in this article will go far toward decreasing problems with retrospective review, not only by the PRO, but also other third-party characters, as well as decreasing the risk for malpractice litigation. While the documentation requirements may often seem onerous and overbearing, it must be realized that the written medical record is the only tool that a retrospective reviewer, either in an insurance setting or the courtroom, can use to assess the care that was provided to the patient. I can congratulate you on providing such a well-written article to educate the constituency of *OHIO Medicine* to many of the issues that we have been stressing for a number of years now.

Steven L. Richardson, MD
Vice President of Medical Affairs
Peer Review Systems, Inc.
Columbus

Correction

In October, the "Colleagues" column incorrectly identified William Smead, MD as chief of staff of the division of neurosurgery at Ohio State University Hospitals. Michael Miner, MD, PhD is the chief of staff. *OHIO Medicine* regrets the error and any confusion it might have caused.

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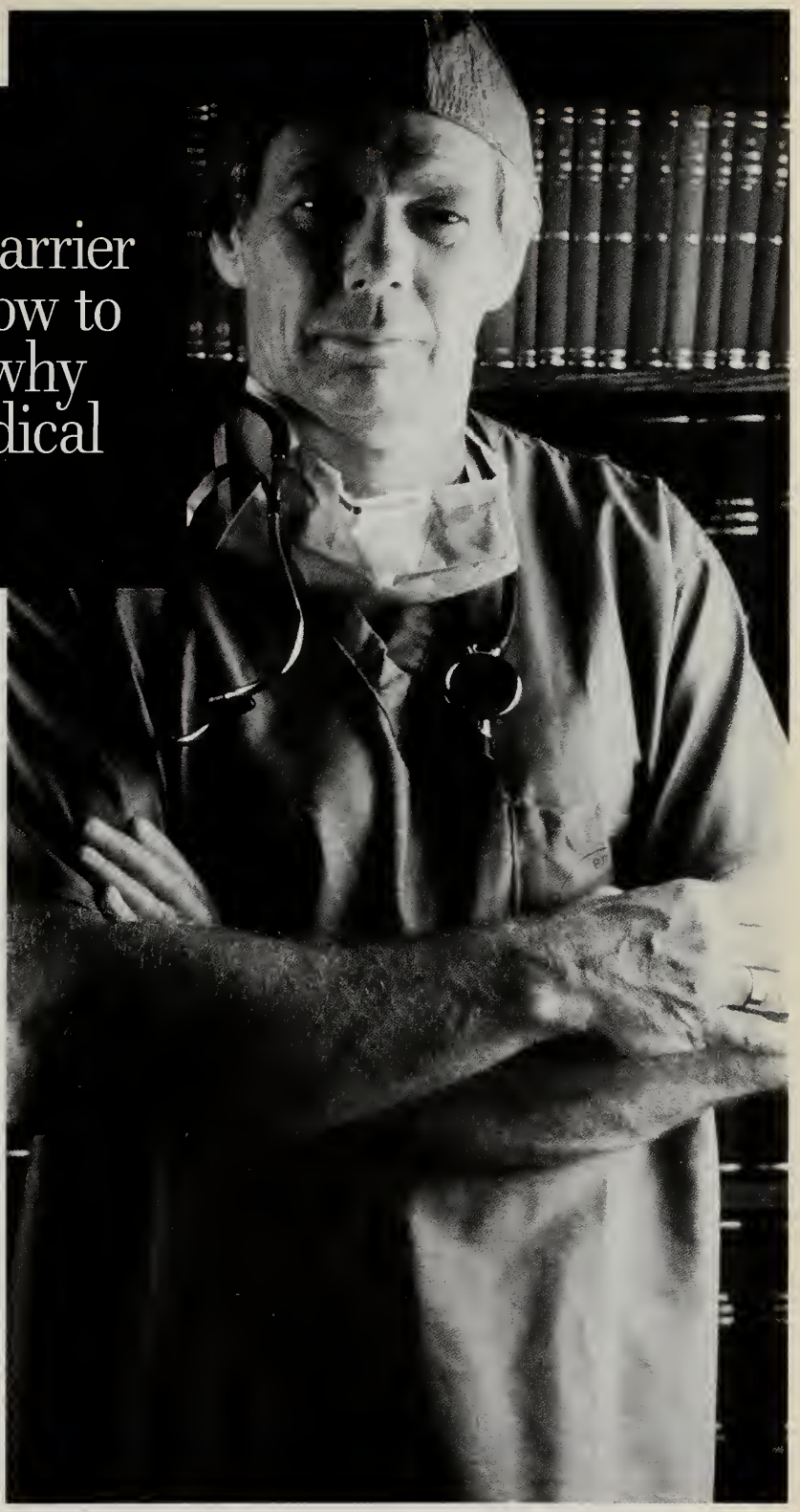

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Balloon Man

By John Stone, MD

Editor's note: *The following article was submitted to us by Dr. Stone. It originally appeared in the* **New York Times** *magazine.*

In his poem that begins "In Just Spring," e.e. Cummings speaks of the beguiling "balloonman [who] whistles far and wee." In 1980, when I first met Andreas R. Gruentzig, a real-life balloon man, I thought of that line. Dr. Gruentzig was a pioneer, the first person to work therapeutically *within* the coronary arteries, a feat of considerable derring-do. This year in the United States, more than 200,000 balloon dilations of the coronary arteries will be done, using the technique developed by Gruentzig (who emigrated from Zurich to Atlanta in 1980). Physically, Andreas had a certain resemblance to Errol Flynn, the cinematic risk-taker; he was slender, with penetrating eyes, a ready smile and a mustache. As Cummings would have said, "Jesus, he was a handsome man . . ." Physical features and charisma aside, though, Andreas Gruentzig was a world-class scientist, who gave full credit to those who had preceded him: Werner Forssmann, for example.

In 1929, Forssmann, a 25-year-old German physician, was assigned to a small clinic in Eberswald. He was convinced that the heart could be entered safely with a small tube, or catheter. His superior had forbidden such dangerous research, but the impatient young man began anyway. In order to obtain sterile instruments, he needed the help of a nurse. As part of a ruse, he persuaded a nurse to let him try the procedure on her. After she'd obtained the sterile tray he needed and had stretched out on the operating table, Forssmann strapped her down so she couldn't interfere. He then sterilized his own arm, and, using local anesthesia, made an incision near the elbow, and isolated one of his veins. The tube slid in easily, to its total length of 26 inches, far enough to reach the interior of his heart. He felt no pain, he said, only a feeling of "warmth" behind his collarbone as the catheter slid along under it. Forssmann released the incredulous nurse and the two walked down several flights to an X-ray room. The tube was, indeed, in the heart. Research based on this courageous self-experiment began, but 27 years passed before its full impact was realized. In

Dr. King speaks to her softly, telling her she's to remain in bed, overnight, on heparin; if things go well, she can go home tomorrow.

1956, along with Drs. André F. Cournand and Dickinson W. Richards (who applied Forssmann's work to patients), Forssmann was awarded the Nobel Prize. Of this honor, he is reported to have said, "I feel like the village parson who has just learned that he has been made bishop."

In the early 1960's, Drs. C.T. Dotter and M.P. Judkins of the University of Oregon passed progressively larger dilating catheters to open narrow leg vessels. Dr. Mason Sones of the Cleveland Clinic had shown the coronary arteries could be safely and selectively injected with dye. The medical woods are full of risk-takers.

This afternoon, Dr. Spencer B. King III, director of the Andreas Gruentzig Center at Emory, is to perform a balloon angioplasty on a woman in her late 50s. As King and I arrive at the cath lab, the patient is already on the table. A cardiology fellow has completed the preliminaries: First, he used a needle to puncture the femoral artery at the top of the leg. Then he passed a flexible guidewire through the needle (which was then withdrawn). Finally, over the guidewire, an ordinary, thin catheter was slipped into the vessel. The catheter can be seen now, on fluoroscopy, as it moves against the current in the aorta. The catheter, about three feet long, curves gently around the arch of the aorta and turns downward toward the heart and the coronary arteries. The two coronary arteries, the right and the left, have a critical function — they nourish the heart itself, taking off from the aorta just as it leaves the heart. Angiographers know where the coronary artery openings are simply by having been there so many times. In seconds, the tip of the catheter shallowly engages the opening of the right coronary artery. A brief puff of dye into the artery confirms the catheter's precise position; the artery is invisible except when this dye is injected.

The patient's chest pain is caused by a narrowing in the right coronary artery. The narrowed segment is rather long, nearly an inch, which can lead to technical problems — the mortal clay of a narrowed coronary can crack under pressure from the balloon, so the artery is approached warily. An angioplasty catheter with an inch-long deflated balloon attached near the tip is unpacked from its sterile wrap. This catheter, small in diameter (the size of a pencil lead) and flexible, is actually a double-barreled tube: one barrel for injection of dye and for measuring blood pressures; the other carries a solution to inflate the balloon.

The balloon catheter is now guided into the culprit coronary artery; it is threaded gingerly past the narrowed area. The patient is asked, over and over, "Any chest pain?" because the balloon catheter itself further reduces blood flow in the artery. The balloon is centered across the obstruction: Blood pressures above and below the narrowing show a 66-millimeter difference (the pressure being higher above the obstruction), which helps gauge the severity of the problem and the efficacy of the treatment.

The balloon is inflated for only a few seconds, puffing up to the shape of a sausage about an inch long and an eighth of an inch in diameter. It's then blown up again for a full minute.

The first time, the woman has chest pain, but the pain passes. After the second inflation, the pressures are almost equal, as they should be, indicating that the narrowed passage has been successfully widened. Injection of dye reconfirms this happy fact. The angiographer's work is done, except for showing the patient, on a television replay, the before and after of her artery.

Dr. King speaks to her softly, telling her she's to remain in bed overnight, on heparin, a blood thinner, to prevent clotting; if things go well, she can go home tomorrow. Finally, she gets a last reminder from Dr. King: "Remember our agreement, now: no smoking. Ever again, O.K.?" "O.K.," she replies, grinning a relieved smile.

It was Andreas Gruentzig's genius to recognize the potential of the balloon catheter. In the early 1970s, at the University Hospital of Zurich, he worked tirelessly to develop catheters and balloons using different materials to

enhance *flexibility* and *thinness.* He then used these balloon catheters to open vessels that are larger in diameter than the coronary arteries, such as those to the kidneys and legs. Finally, in September 1977, he identified an appropriate patient, a man with angina due to a single narrowed artery. After seven years of work, Andreas Gruentzig was ready to take on the coronary arteries.

A contingency plan was in effect: If something went wrong, a surgical team was ready to perform an emergency bypass of the vessel. In fact, that day there were several prominent onlookers, including the chiefs of surgery and cardiology. To Dr. Gruentzig's relief, the catheter slipped through the narrowed artery relatively easily. The balloon was inflated. The narrowed area widened nicely. History had been made.

A few months later, after performing the same operation on four additional patients, Gruentzig shared his triumph with the medical world in a paper to the British medical publication *Lancet.* Thereafter, people from all over the world came, first to Zurich, and, beginning in 1980, to Atlanta, to discuss the problems and potential of this new technique. Over the next few years, Gruentzig and his colleagues performed several thousand angioplasties. The technique was demonstrated and taught to hundreds of cardiologists in postgraduate courses. (The courses utilize a huge video screen and offer voice-over communications between the "operator" in the cath lab and the audience of several hundred in the auditorium.)

Much research continues today — for example, lasers are being tested as a supplement to the balloon technique. Answers to many questions are being sought, among them whether angioplasty or bypass surgery is better in a given patient. Angioplasty is quicker and less traumatic; bypass surgery requires opening of the chest. But arterial narrowing recurs in perhaps 25% of patients after angioplasty, a problem that has not yet been solved (angioplasty *can* be repeated). And premier angioplasty labs need to have a surgical team on standby for emergencies that might occur, an expensive proposition.

Unfortunately, Andreas Gruentzig was not destined to learn the answers to these questions. The world has a special place in its collective memory for those who die young, a group to which Dr. Gruentzig and his physician wife were added on Oct. 27, 1985; they were killed when the plane he was piloting crashed. He was 46 years old.

In September 1987, 10 years to the day after the first historic angioplasty in Zurich, the original patient came to Emory for doctors to have another look at his arteries. In the words of Spencer King's secretary, "Dr. King injected the dye . . . and on the big screen came this wonderful picture of arteries that looked — I hope mine look as good as his were — and the whole audience was just so stunned by this finding, and everyone burst into applause." It was a haunted moment, one that Andreas Gruentzig would have cherished and perhaps followed with a brief bow.

John Stone, MD, is a cardiologist at the Emory University School of Medicine and is a poet whose third book is "Renaming the Streets."

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Senseless! Senseless! Senseless!

By William H. Havener, MD

It makes no sense at all. Half a hundred candles blazing at the front of a Columbus church the evening of December 12. Each candle in memory of a victim of a drunken driver. The entire church blurred by the tear-filled eyes of those attending the annual Mothers Against Drunken Driving Candlelight Vigil. A sea of candles held aloft in silent and sad remembrance. An ocean of salty tears, flowing freely.

MADD was founded only a short seven years ago in the wistful hope that the future would demand no more candlelight remembrances, that future American families would no more lose 25,000 loved ones each year, that we would all be safe from the crippling and widowing and orphaning actions of those irresponsible persons who deliberately gamble with *your* life.

Drunken driving is not an accident, not a tragic quirk of fate, not a victimless crime. Drunken driving is the deliberate and knowing possession of the keys to a vehicle, with the full and premeditated intent of driving that vehicle. Drunken driving is the conscious and intentional action of seeking and consuming the first drink with the full and experienced knowledge that a second drink always follows the first, and then a third and more follow. Although inebriated actions are beyond cognitive control, the fact remains that a series of conscious, *intentional,* premeditated and sober actions precede drunken driving. The devil isn't to blame. Intentional, conscious, personal decisions result in the combination of drinking and driving. A drunken driver does not just happen. The decisions of that individual are responsible for the situation. Is it acceptable that 25,000 of our friends and relatives are *murdered* each year by these deliberate actions of drunken drivers? That several hundred thousands of us are crushed, dismembered and otherwise mutilated? As a physician, I think first of the consequences of death and suffering and sorrow. Perhaps we so worship the almighty dollar that more persons would be stirred to action to protect the over a *hundred billion dollars* of monetary damage caused annually by drunken driving — our prized new automobiles reduced to junk in the second of impact, the social cost of lost productivity and medical expenses.

No one is spared. The next time you sit with friends at a table, surely at least one of the group will have a relative or friend who has paid the price of being the victim of a drunken driver.

How long would we tolerate a hungry lion whose unsatiable appetite was the commonest cause of death of our community teen-agers? You know the answer. Armed men would track the beast day and night until its lifeblood poured from its bullet-riddled body.

So why do we tolerate the mass catastrophe of drunken driving? The civilized answer is that we must be patient, considerate of the rights of the murderer and despoiler, and sympathetic with those victims who weep and stage candlelight vigils. Patient, hell! Be patient with the murdering and maiming of our children, our friends, our wives and husbands! That's garbage. The beast of drunken driving must be put to death. If you had attended the MADD candlelight vigil, you would know why MADD says you must be spared that ordeal.

Another excuse might be that we can do nothing about drunken driving. There aren't enough jails. Not enough judges and policemen. Doesn't help to suspend licenses; they drive anyway; they can't be stopped. All these excuses are accurate with respect to our present approaches. As of now, society pays for all this — for the jails, judges, police, the tragedy, death, property loss. The drunken driver wheels away to meet his next victim. That's crazy. Why

Drunken driving is not an accident . . . drunken driving is the deliberate and knowing possession of the keys to a vehicle, with the full and premeditated intent of driving that vehicle.

should society pay for the actions of the drunk?

The solution is so simple and obvious that a child could recognize it. Make the offender pay. Create a penalty that will make the crime of drunken driving impossible. And don't charge it to society.

The penalty? Confiscate on sight every vehicle operated by a drunken driver or by a driver whose license is suspended for a drunken driving offense. You can drive without a driver's license, but you can't drive without a vehicle. Cruel, heartless and illegal, you will protest. Be reasonable. The alternative is the present murder, maiming, suffering, tragedy and destruction, all suffered by innocent bystanders. Why should the innocent pay such a price instead of the offender? Where is the justice in claiming the present system is to be preferred? Would you rather have walking drunks or widows and children standing at gravesides?

The learned jurists and the protectors of civil liberties will claim you can't confiscate private property such as an automobile. That's ridiculous. If I bootleg untaxed cigarettes across a state border, my car can be confiscated. If I drive through Columbus with a trunk full of cocaine, my car can be confiscated. If I simply shine a flashlight from my car at a deer and shoot it, my car can be confiscated. If I threatened your kid with a gun, do you really think the police would let me keep the gun? What's the difference if the police stop me for drunken driving one block away from where your kid is playing? Ten feet away from where your kid is playing? Ten blocks after I pass the spot where your now-dead kid used to be playing? The only difference I see is the bloody guts of your kid smeared all over the street like the squashed raccoons littering Route 315.

Let's call it the way it is. The drunken driver preceded that condition with conscious and sober intentional and deliberate actions that resulted in his being prepared to kill you if you unknowingly got in his way. Does he have a right to do that? Do you have a right to outlaw this action? You won't let me point a loaded gun at your kid. Why would you let me point two tons of drunken-guided steel at you?

I plead with you. I still have tears in my eyes from the candlelight vigil and the aisle full of widows, grieving husbands, tear-stained children and wheelchair-carried victims. This slaughter is senseless, intolerable, and cannot be allowed to continue.

Tell your family, friends, legislators, lawyers, judges, everyone. Tell them of your friend and loved one whose harm touched your own life with tragedy. Tell the world that in Ohio we will cut off your wheels if you drive drunk, that the drunken or suspended driver will pay the penalty of instant loss of his vehicle instead of society paying for his misdeeds. Have we any other reasonable choice?

Which would you really rather read in tomorrow's newspaper? "Only three more drunken drivers walk this week — they're finally getting smarter." Or "The grieving survivors include (your name here)." **OSMA**

William H. Havener, MD, is a Columbus physician.

OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians

America's newest import

Cars and wine aren't the only products America is importing these days. Blood, imported from Europe, is now being used to bolster this country's dwindling blood supplies.

The demand for blood — for surgery, emergencies and treatment of cancer and other diseases — can no longer be met by domestic shipments from regions with surpluses, so, for the first time, the American Red Cross is importing blood from abroad.

Imported blood must undergo the same safety tests as blood that is collected in this country, and, while officials won't discuss costs, blood centers claim it's cheaper to buy voluntarily donated European blood than to collect it locally. Some centers, in fact, are no longer using mobile units to collect blood because costs of collection from a small number of donors are too great.

The amount of blood being imported is relatively small at present, but officials are concerned about a reliance on imported blood, saying that blood could become vulnerable to international politics.

Economics and an erosion in community spirit are cited as principal reasons for America's chronic blood shortage and reasons for importing European blood.

AZT to cost less

The AIDS drug AZT, or azidothymidine, may soon become more obtainable for AIDS patients.

Burroughs-Wellcome Company, the only company that manufactures AZT, recently lowered the drug's price by 20%, and claims it will provide the drug free of charge to uninsured AIDS patients, following mounting protests about the drug's cost, led by advocates for people with AIDS.

One day's supply of the capsules contains about 15 cents worth of ingredients, but when purchased by an AIDS patient, the drug typically runs about $9. A lifetime of treatment with AZT could add up to a lot of money, but the new prices should help.

Research suggests that AZT not only helps people with AIDS or severe AIDS-related illness, but also forestalls AIDS in people at earlier stages of infection with the AIDS virus.

Fear of falling can be incapacitating

If one of your elderly patients has assumed, lately, an abnormal, slow or shuffling gait, clutches people or things while walking, and has talked to you and others a great deal about a fear of falling, you may suspect that patient has recently taken a tumble and is suffering from "post-fall syndrome."

According to Barry Hong, a medical psychologist at Washington University School of Medicine in St. Louis, who is studying the problem, "post-fall syndrome" is a disorder that can cause anxiety and depression, two risk factors that often cause falls to take place.

The fear of falling can become so great that the elderly victim may refuse to leave the house, eliminating all outside activities.

Yet, according to the Gerontological Society of America, fear of falls may not necessarily be ungrounded. The society estimates two out of three accidental deaths in persons over 75 may be attributed, directly or indirectly, to falls, and certainly bone fractures, especially those involving the hips, soar exponentially after that age.

While science and medicine are making progress in understanding falls in the elderly, they have a long way to go to prevent them.

So, be aware of the patient who shuffles into your office, proclaiming a fear of falling. Until medicine comes up with an effective prevention against falls, you may want to give your patient some guidelines to minimize the risk and, depending on their emotional state, refer them to a mental health professional.

Gauging your pace

If you live in Boston, your chances of having heart problems are great — but according to a study done by *Psychology Today*, Columbus residents need to watch their steps too.

The study correlated fast-paced cities to coronary heart disease. Researchers used three measurements in gauging a city's pace: how fast residents walk, how long bank clerks take to make change, and how fast postal clerks talk.

The top five fastest-paced cities out of the 36 studied were: 1.) Boston; 2.) Buffalo; 3.) New York; 4.) Salt Lake City; and 5.) Columbus. Californians don't have to worry. Los Angeles ranked last.

COLLEAGUES

J. CRAIG STRAFFORD, MD, Gallipolis, has been elected to the Board of Trustees of the American Group Practice Association . . . **GLENN BARTLETT, MD,** Coventry Township, has been named the recipient of the Outstanding School Volunteer/Partner Award in recognition of his service to Coventry schools . . . **STANLEY E. ROWAN, MD,** Bryan, has been named medical director of Park View Nursing Center in Edgerton . . . **WILLIAM R. SCHULTZ, MD,** has been recognized by the Wayne County Medical Society for his 50 years of medical practice . . . **WILLIAM M. GARRETT, MD,** Chillicothe, has received a Distinguished Service Award from his alma mater, Muskingum College . . . **RICHARD SIMPSON, MD,** Gallipolis, has been appointed vice president of the executive committee of the Ohio Chapter of the American Academy of Pediatrics . . . **BRUCE ROTHMANN, MD,** Akron, has been awarded the National Distinguished Eagle Scout Award, which is meant to honor Eagle Scouts who have distinguished themselves in their careers or public lives. Dr. Rothmann became an Eagle Scout in 1938 . . . **WALTER MATERN, MD,** Cincinnati, has been named the 133rd president of the Academy of Medicine of Cincinnati . . . **TERENCE KILROY, MD,** Cleveland, has been named to the Board of Directors of the Academy of Medicine of Cleveland . . . The following physicians have been named cancer liaison physicians under the Commission on Cancer of the American College of Surgeons: **M.M. RESSALLAT, MD,** Galion, Galion Community Hospital; **MICHAEL A. FLYNN, MD,** Akron, Akron City Hospital; and **PHILIP D. LEMING, MD,** Cincinnati, Mercy Hospital . . . **DONALD HARRISON, MD,** Cincinnati, has been elected to the Board of Trustees of the American Heart Association, Cincinnati area . . . **WILLIAM R. BRINKER, MD,** Ravenna, has received the 1989 Distinguished Physician of the Year Award from his colleagues at Robinson Memorial Hospital. The award is given annually to an RMH physician who has completed outstanding achievement in the field of medicine . . . **JOHN W. RAY, MD,** Zanesville, has been named the Ohio public education representative of the American Academy of Otolaryngology — Head and Neck Surgery . . . **LAWRENCE G. THORLEY, MD,** Amherst, has been appointed director of the Central Trust Company of Northern Ohio . . . **JAMES B. BESUNDER, MD,** University Heights, has been named head, pediatric intensive care unit and director, pediatric critical care and clinical pharmacology at Metrohealth System.

Hospital closes its door to lepers

The country's only remaining hospital for Hansen's disease, or leprosy, in Carville, Louisiana, has closed its doors.

The Gillis W. Long Hansen's Disease Center, the last hospital operated by the federal Public Health Service, will be consolidating its facility over the next three years, relocating its research and clinical functions to nearby Baton Rouge, and attempting to place treatment on an outpatient basis.

According to news reports, medical experts now believe that leprosariums are a thing of the past, and that treatment for the once-disfiguring disease can be provided adequately within the community. They point to advances in treatment that have made leprosy the least contagious of all communicable diseases (approximately 20 million people worldwide suffer from the disease, although only 6,000 cases exist in the U.S. About 100 new cases are diagnosed each year).

Hansen's patients, however, are reluctant to move out into the world, fearing the reaction of an often hostile and misinformed society.

"I've got three girls and two boys, (but) they don't want me to be around their children," says one patient, quoted in an article in the *Dallas Morning News*. Society's misgivings proved too much for the patient. "I just locked it (her home) up and walked out" she says — eventually finding comfort with other Hansen's patients at the center.

"It's horrible," she says now about the closing. "I'm going to stay here 'til they run me off."

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OHIO MEDI-SCENE

Reproduction therapy . . . the future of American medicine . . . 50-year physicians . . . art for the people . . . gender-neutral language . . .

Reproduction therapy: new frontiers for the 1990s

In March, 1988, *OHIO Medicine* tackled the subject of reproduction technology — extensively. One year later, it's time to do it again.

Assisted reproduction therapy is a field that continues to develop as researchers find new and better ways to help childless couples conceive the offspring they want. Of course, as these innovative techniques are created, so too are new ethical dilemmas which continue to cloud these "miracles of medicine."

Both the new developments — and the ethical dilemmas they produce — were discussed by Columbus reproductive endocrinologist Steven Williams, MD, during his presentation "New Reproductive Technologies — What's In Store for the '90s?", a part of Riverside Hospital's alumni reunion, held this past September.

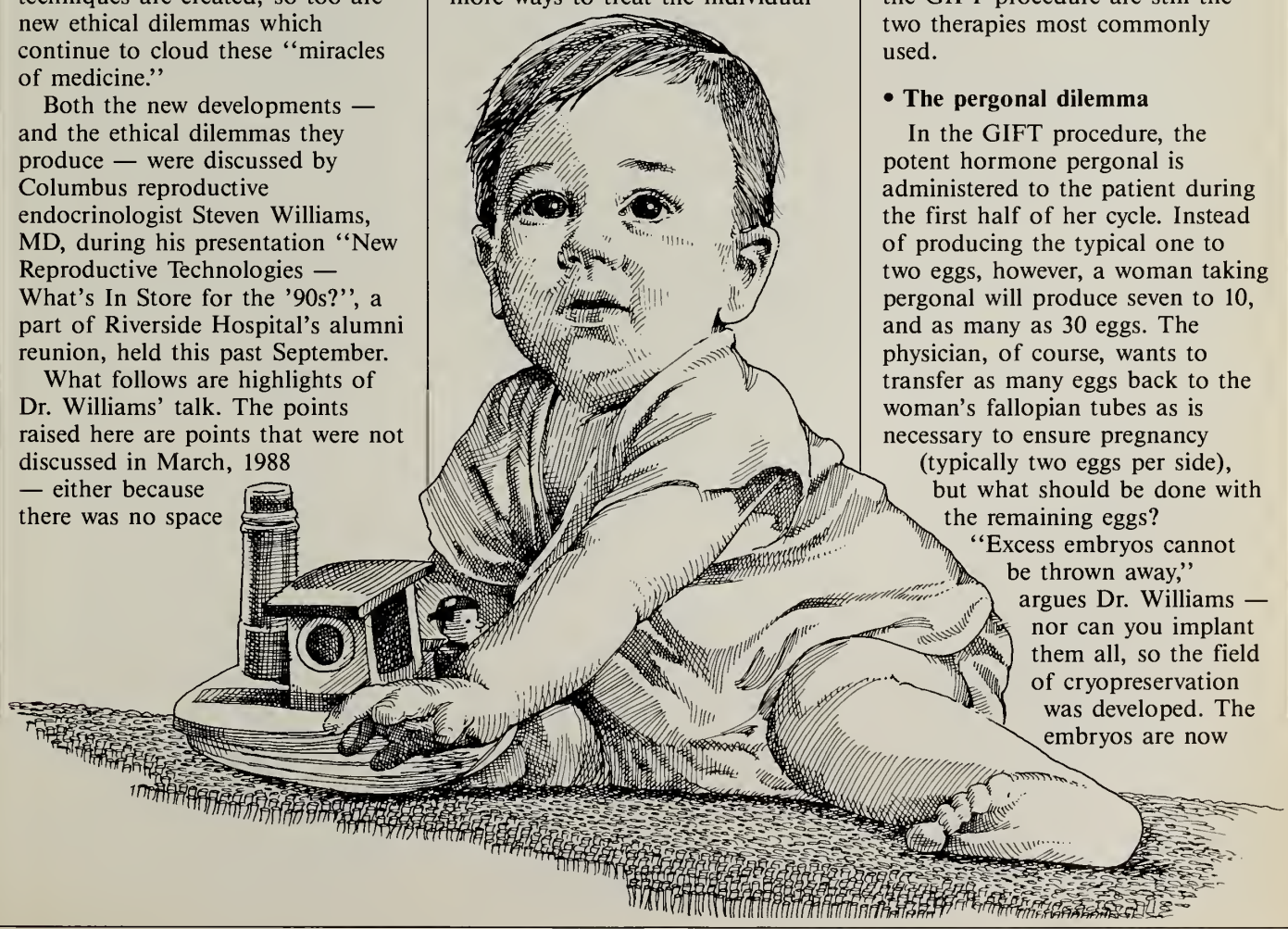
What follows are highlights of Dr. Williams' talk. The points raised here are points that were not discussed in March, 1988 — either because there was no space available, or because they were simply not around at the time those articles were written. What's in store for infertile couples in the 1990s? Here is a small sample:

• Less need for reproduction therapy

"In the future, fewer women will need assisted reproduction therapy, as medicine discovers more and more ways to treat the individual factors that make them infertile," says Dr. Williams.

Presently, the number of unexplained cases of infertility is decreasing because there is more diagnostic technology available today to discover what is wrong — and how to treat it.

For those who do move on into assisted reproduction therapy, however, in vitro fertilization and the GIFT procedure are still the two therapies most commonly used.



• The pergonal dilemma

In the GIFT procedure, the potent hormone pergonal is administered to the patient during the first half of her cycle. Instead of producing the typical one to two eggs, however, a woman taking pergonal will produce seven to 10, and as many as 30 eggs. The physician, of course, wants to transfer as many eggs back to the woman's fallopian tubes as is necessary to ensure pregnancy (typically two eggs per side), but what should be done with the remaining eggs?

"Excess embryos cannot be thrown away," argues Dr. Williams — nor can you implant them all, so the field of cryopreservation was developed. The embryos are now

Reproduction therapy . . . *continued*

preserved by freezing them.

"But the pregnancy rate from these previously frozen embryos is disappointing," says Dr. Williams. In fact, he continues, there is only a 5% chance of conceiving from a frozen embryo.

Cryopreservation also creates a number of ethical dilemmas — i.e. what does one do with the eggs in the event of the death of both parents? Is "custody" awarded in a divorce? Front-page news was made this summer as a Tennessee couple became locked in a heated court battle over the fate of their frozen fertilized eggs. Closer to home, a Cincinnati couple, in similar circumstances, opted to donate the eggs anonymously to another couple.

Oocyte donation has raised yet another dilemma, however.

"Women want their sisters to donate the necessary eggs," says Dr. Williams. "So far, we haven't done that. All of the eggs we use come from anonymous donors." Yet there may come a time in the future when sisters will be donating eggs to sisters — and a new crop of ethical problems is bound to follow.

• Micromanipulation

As the field of assisted reproduction technology matures, more sophisticated, and in some cases, bizarre, techniques have developed from the research that continues in this area.

Zona drilling was first presented two and a half years ago, and involves a physician actually performing surgery on the egg. According to Dr. Williams, zona drilling has so far been performed on 10 couples, and while fertilization has been achieved, there are still no pregnancies.

Dr. Williams, in fact, doubts that certain micromanipulation techniques will be successful. "One group of researchers injected sperm into the middle of any egg, but it didn't work," he says. "In my opinion, a lot of things connected with fertilization happen in the membrane of the egg. You can't dump things in the middle and expect it to work."

Another micromanipulation technique known as partial zona dissection, where sperm are injected into the zona and incubated, has produced a pregnancy.

Micromanipulation appears to be the newest development to date, for treating the male-related causes of infertility resistant to more traditional in vitro fertilization (female factors still comprise 50%-55% of the reasons for sterility), but as Dr. Williams explains:

"Treatment of the male factor is the most frustrating part of our practice."

The advantage micromanipulation, or microinjection, offers is that only one sperm is needed to fertilize the egg. By comparison, a man on the average needs to produce 20,000,000 sperm for a normal conception while only 50,000 motile sperm are needed for the GIFT procedure, and 100,000 sperm for in vitro fertilizations.

"More research will be done in this area in the 1990s," predicts Dr. Williams

• Experimental techniques

Of course, as research in this field advances, there are the inevitable experiments that appear to have been lifted straight out of some science fiction tale. A recent Italian experiment on an extracorporeal uterus is one such example.

"The uterus was taken into the lab, perifused, and embryos were transferred into it. Implantation was confirmed," Dr. Williams comments. "I have to believe that the experiment was done as a lark, and that further research in this area won't continue."

But an artificial womb is just one of the ethical concerns that such experimentation is raising. Technically, medicine is reaching the point where genetic engineering and cloning are merely a step or two away.

For example, it's possible for a researcher, holding an embryo in place with a pipette, as in micromanipulation, to dissect off a blastomere, freeze the embryo, then amplify the blastomere's genetic message. This could then be used to determine the genetic makeup of the frozen embryo.

The positive side of this is that inherited medical problems, like sickle-cell anemia, can be cured through genetic engineering.

"More scary is the thought that we could amplify those traits that can help a boy run down the football field faster," says Dr.

Williams. "It's not being done, but such genetic engineering is possible."

So, too, is cloning, and it's conceivable that at some point in the future clones with a person's genetic makeup will be frozen and, when necessary, be called on to grow new hearts, brains or whatever is needed for the clone's counterpart to sustain life.

Technically, it will be possible. Ethically, however, medicine will have to set some limits.

• Cost factors

The expense involved in all of these procedures will, naturally, limit what will and won't be done and on what type of scale.

"Insurance on this matter is in a state of flux," says Dr. Williams. Most insurance companies until recently would cover assisted reproduction therapy, up to their own defined limits.

"Now they're saying these procedures are experimental, and we won't pay," continues Dr. Williams.

This pronouncement, however, produced a public outcry so intense that it catapulted mandated insurance coverage for these procedures (with caps) in seven or eight states. In two of these states — Delaware and Maryland — the insurance cost per person went up a negligible amount . . . 50¢-$1.06 . . . "to provide coverage that approximately one in six patients will need," says Dr. Williams.

The Ohio House of Representatives has already passed a bill mandating similar coverage in this state, and the bill currently awaits decision in the Senate.

"Consumerism is effectively lowering the costs of these procedures," adds Dr. Williams, and as more and more of these procedures become office-based, costs are bound to drop even lower.

Congress, however, is keeping a close eye on the quality of the numerous in vitro clinics and infertility programs that have sprung up all over the country.

"There's no question that the procedures are heading in favor of consumerism," says Dr. Williams — but he doesn't appear to be bothered by this direction.

"After all," he points out, "we are in the business of helping people have babies." — *Karen S. Edwards*

The future of American medicine: busting the myths

James E. Davis, the North Carolina surgeon who last year presided over one of medicine's most august bodies, the American Medical Association, gripped the podium and stated his mission.

"I hope I give you something to think about," he told the roomful of Riverside Hospital alumni who return to Columbus each year for a reunion highlighted by a scientific session. At this year's session, Dr. Davis chose to address the subject "American Medicine. Today and Tomorrow" — a thought-provoking topic to be sure.

"I disagree with those speakers in medicine who say that these are the best of times and the worst of times," he continues, "because this is the worst period in medicine that I can remember. This country has many major problems." He points out that even though Americans today are receiving the best health care the world has ever known, it's being muddied by the dilemmas of long-term care funding; soaring infant mortality rates; the un- and under-insured; and the intrusion into medicine by a number of different entities.

And while doctors struggle to protect their patients — serving as the best, and in many cases, only advocates these patients have — an unfriendly, hostile public continues to bash away at the doctor's image, and to clamor for a system, like the Canadian health-care system, that they believe will put an end to all of those major problems Dr. Davis alludes to.

"Believe me, a Canadian system is not what we want in this country," says Dr. Davis. "A system such as that . . . is not placeable in another society."

Physicians, too, are looking for an immediate cure to these problems, but the AMA's immediate past president urges them to be patient.

"Things in health care don't happen rapidly," he comments.

He remains optimistic about medicine's future, however.

"If we are allowed to do what we have been trained to do, and which we do well, the future is unlimited, and we'll be able to achieve those breakthroughs that we're on the brink of today," he says.

Much, however, hinges on "factors beyond our control. That's what we have to pay attention to," says Dr. Davis. "We have to realize that a large part of our future depends on how we do the job, and on how our

OHIO MEDI-SCENE

The future of American medicine . . . *continued*

performance is perceived by both the public and elected officials.''

What can physicians do to preserve the future of health care in this country? Dr. Davis has a few suggestions:

1.) Continue to deliver quality, ethical medicine, despite the obstacles that have been placed in the way.
2.) Clean our own house, and rid ourselves of immoral, unethical, unqualified physicians.
3.) Involve all professionals in the work of organized medicine, instead of allowing only a few to shoulder the load.
4.) Educate the public and elected officials — especially about the myths and misconceptions about health care.

According to Dr. Davis,, a number of these ''medical myths'' exist. He enumerates:

Myth: Spending is out of control, so let's abolish this system and find another.

Dr. Davis: ''Wrong. That's not going to solve the problem. The Canadian health-care system is not the answer.''

Myth: Twenty to 30% of patient services are unncessary.

Dr. Davis: ''That's untrue. The government-controlled peer review organizations that monitor health care put unnecessary hospitalization at 2%-3%, and Medicare deems only 2% of its bill charges as 'medically unnecessary.' ''

Myth: Expenditure targets and caps on government spending will lower health-care costs.
Dr. Davis: "Expenditure targets equal rationing of care. Once the cap has been paid, the doctor goes unpaid for the rest of the procedure. This will put the physician in an adversarial relationship with the patient."
Myth: Physician income has risen disproportionately and unreasonably.
Dr. Davis: "Not true. Doctors have had only a modest increase in their salaries over inflation."
Myth: Doctors won't control costs, so we'll put on a ceiling.
Dr. Davis: "There should be parameters of care. Parameters do work, and physicians will follow them . . . if they are accurate."

Finally, Dr. Davis adds to that need for public education, a need to improve the public's image of physicians.

"Doctors need to be viewed by the community as being public and service-oriented — even though we already are," he says. "We need to participate in community activity that does not reflect on any need for prestige or higher income."

> ***"Doctors need to be viewed by the community as being public and service-oriented — even though we already are."***

He points to the team physicians at local high-school sporting events as one good example of how doctors can get involved in this type of patient education.

"Find four hours in your week for community involvement. Teach a Sunday school, become a docent in a local museum, participate in your community's Meals on Wheels program, or in any activity where you won't come across as a sequestered person of wealth," he advises. "These are terrible times for medicine — why encourage more?"

Still, Dr. Davis admits that he's "big" on medicine's future, and if he had it all to do over again, he would still select medicine as a career.

"It reminds me of the story of Michelangelo and his teacher. His teacher tried to talk him out of sculpting as a career. He told Michelangelo that talent was cheap — but that the dedication to the craft was expensive, and that ultimately it would cost him his life.

" 'Sir,' responded Michelangelo, 'what else is life for?' "

Whether or not the story is true is irrelevant. In its telling, however, Dr. Davis completed his mission . . . he's given you something to think about. — *Karen S. Edwards*

OSMA salutes its 50-year physicians

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Out of State
Arthur Glenn Groscost, M.D., Salem, S.C.
Robert D. Berkebile, M.D., Ft. Myers, FL
John Richard Lutz, M.D., Ft. Myers, FL
Delbert A. Russell, M.D., Naples, FL
Peter Volodkevich, M.D., La Jolla, CA

Twelfth District
Ida Djung, M.D., Akron
Devitt L. Gordon, M.D., Akron
Edgar A. Knowlton, M.D., Mantua
Louis A. Lame, M.D., Stow
Armond L. Leiby, M.D., Akron
Stanley W. Olson, M.D., Rootstown
Stephan C. Strateff, M.D., Columbus
Walter B. Webb, M.D., Ravenna
Out of State
Glenn V. Hough, M.D., Sebring, FL
Margaret Hyde Moore, M.D., Woodland Hill, CA
John Arthur Moss, M.D., Sarasota, FL
Leo Harland Roszell, M.D., Leesburg, FL
George Van Buren, M.D., Bradenton, FL

Trumbull Memorial Hospital visitors enjoy artwork.

Art for the people

People enter Trumbull Memorial Hospital under a star — a star not just for Christmas but for all seasons. "Astra," derived from the Latin proverb "ad astra per aspera," meaning to the stars through hardship, floats over the three-story lobby. The suspended sculpture, by Cleveland artist John Clague, has become the hospital's symbol of hope and endurance.

One cannot enter Trumbull Memorial without being touched by art. Surrounding "Astra" are examples of contemporary works of established artists from the area. Paintings of emotional and

OHIO MEDI-SCENE

Art for the people . . . *continued*

analytical beauty, paper and steel creations, weavings and batiks, all show the viewer that in the hands of an artist, any material can serve as art material. Currently the ART FOR TMH collection consists of almost 1,000 pieces — about 600 masterpiece posters from American museums and 400 originals.

The concept of ART FOR TMH originated with a simple request made four years ago. "Could you please put a few colorful touches in the new Birthing Unit?", Charles A. Johns, TMH president asked of me — obviously because of my longtime involvement with the Trumbull Art Guild.

Choosing paintings of local women artists to welcome the mothers and their new babies seemed an appropriate idea. Before long, pictures of flowers and birds, homes and gardens filled the unit — a happy world painted by women for women.

"Creating a work of art is much like giving birth to a child," explains painter Shirley Wolanzky, "and who could keep us from that? I could stop painting about as easily as I could have stopped in the middle of labor and decided not to have a child. It is something that is within me and must come out . . . "

Wolanzky's message helps us understand the nature of an artist and the compulsive process of producing a work of art. The paintings enhanced the working environment, and it was not long before other departments wanted some pictures too.

Marianne Pich-Nissen shows off the art that she helped to collect and coordinate for Trumbull Memorial Hospital.

"Adopt a painting for your hospital"

One could hardly expect the hospital to start investing significant capital in artwork. As so often happens in the art world, funds had to be sought elsewhere. On Oct. 6, 1985, with the help of the Trumbull Art Guild and Youngstown Butler Art Institute, a one-day exhibit was arranged in the hospital's lobby. "Adopt a painting for your hospital" read the invitation to the community. "We are proud of our handsome, modernized hospital, its excellent care facilities and experienced staff. We believe you will also share our enthusiasm about highlighting TMH visually, with the best local art we can find, to make it a pleasant place to be treated, to work and to visit." Ninety percent of the exhibited pictures were adopted and displayed in the hospital with a personal plaque announcing the sponsor. Within the range of local artwork, "The Warren Watercolor Collection" was established, and familiar scenes of the Western Reserve area soon became favorites. But in a nine-story, 500-bed hospital, this was still only a drop in the bucket.

Art should be fun

Museum posters offered themselves as an affordable answer for our long, bare hallways. Beautiful and informative, these high-quality reproductions were the next best thing to original masterpieces. They tell the story of the great American museums that house these treasures — museums spread from coast to coast, a source of national pride and prestige. While displaying the posters we kept in mind that first

of all, art should be fun — a diversion from the stress of being in a hospital. Together with my assistant Frances Burns we grouped the posters under various themes. For instance there are "Faces" in the hallway leading from the health clinic to X-ray, faces that have been immortalized in famous paintings throughout the centuries. Among these portraits are faces young and old, happy and sad, stern and strict, kind and jolly. These are faces of people who make us wonder what their world was like and what they would think about ours if they could step out of their frames.

For many this may be the first encounter with classical painting — not everyone goes to a museum but most visit a hospital.

Therefore we equipped every hallway with plaques that describe the groupings as well as each individual piece. Labels give anecdotes about the particular painting and a brief history of the artist. Artists who have battled diseases are pointed out, for often they triumphed over their handicap by continuing to create. For instance, Renoir, the famous French Impressionist, suffered from arthritis at the age of 50, yet his crippled fingers did not stop him. Every morning he had his brush tied to his hand, and he painted from his wheelchair.

Walking through the hospital one can find magnificent Dutch still lifes in the "Hall of Old Splendor"; serene and romantic landscapes from the Hudson River School; ancient and modern Indians under the title "American Paradise; and "treasured things from the past" as well as contemporary "Crafts." Visitors on Surgicare may be impressed by the generation of culture behind our foreign physicians after viewing posters "5,000 years of Korean Art" and "The Enchantment of the Far East." Geropsychiatric patients may remember the past with Grandma Moses' depictions of old American country scenes or count flags, dogs or bunnies in various other primitive and native-style paintings. In Pediatrics, children can observe the development of Michael's talent. Each year, since he was five, he adds one of his creations to the unit's wall.

Art is us

Art speaks to us about life, the world we live in, our emotions, joys and sorrows. Art is for everyone — those who forgot their books, their knitting, who carry lab trays or serve lunch from the food cart. While it may be easier to love the sun-lit paintings of the Impressionists and the dramatic seascapes of Winslow Homer, we find that people, with a little information, can also accept the artistic output of their contemporaries. People meet the challenge when they are challenged. People are curious. At Trumbull Memorial we are able to say with pride that nothing on our walls proved to be too ancient or too modern for our minds and imaginations. — *Marianne Pich-Nissen*

People even read poetry here

In the Kenneth Patchen Coffee Shop, visitors, patients and hospital staff are surrounded by picture poems of this world-famous poet, born here in the Steel Valley. "Caring is the only daring, oh you know it" is one of the many aphorisms painted on the snack bar wall by a laboratory employee. Poetry, one of the least accessible of the Fine Arts, is here quite nonchalantly consumed with a cup of coffee. "Kenneth would have liked this idea," said Miriam, his widow and muse, upon seeing the coffee shop for the first time. "He always wanted to talk straight to the people." Poets visiting the coffee shop during the Patchen Poetry Festival were overwhelmed that their voices were being heard in such a nontraditional environment. Living poets of the area are given a chance to publish their work on the "Poets Column," located just outside the Patchen Coffee Shop.

ART FOR TMH has provided an inspirational background to the hospital's primary mission of patient care. From the beginning, the concept was designed to involve everybody. Through the hospital newspaper, *TOPICS,* employees and friends were informed about the progress. Physicians are enjoying a rotating exhibit in the doctor's lounge. Paintings are sponsored constantly by community members, and tours through the collection are frequently requested. The results of a photo contest are displayed in the patient rooms on the ninth floor.

Art is accessible to all people at TMH. What more can one say when a nurse, who has been in Washington, DC often, now decides to visit the National Galleries with her family and comes home enthused about meeting many of these paintings from our poster collection; when a housekeeping employee gets upset about having to scrub bubblegum from a picture; or when a tattooed young man, wandering around in his undershirt from poster to poster exclaims: "Man! That is really cool, man"?

To learn more about this concept for your hospital, please call Trumbull Memorial Hospital at (216) 841-9123. Brochures, slide presentations and other material are available. — *Marianne Pich-Nissen*

OHIO MEDI-SCENE

Gender-neutral language becomes OSMA policy

Editor's Note: *At its September 16, 1989 meeting, the Council of the OSMA voted to adopt a gender-neutral or non-gender-specific policy for all association publications and all official spokespeople for the association. The issue was originally raised at the 1989 OSMA House of Delegates meeting in the form of a resolution submitted by the Medical Student Section. This resolution, 45-89, was referred to the OSMA Council. Council, in turn, referred it to the OSMA Communications Committee chaired by William Dorner, Jr., MD, Akron.*

After reviewing the issue, the Communications Committee recommended, and Council subsequently approved, the following policy statement:

It is the policy of the OSMA that effective January 1, 1990, all official publications of the association will contain gender-neutral language where appropriate and furthermore, that all official spokespersons for the OSMA will be advised to utilize gender-neutral language when speaking on behalf of the association.

The policy will be implemented in the following ways:

1. The guidelines for submitting a manuscript to *OHIO Medicine* will be altered, and this change in policy will be called to the attention of people who wish to submit articles to the magazine.
2. All articles submitted for publication to the magazine will be edited to make certain that they comply with the new policy. Articles with minor problems will be corrected. Articles that require major editing will be returned to the author for his or her approval before being published.
3. All other publications of the association will comply with the policy.
4. All official spokespeople will be asked to comply with the policy.

To help ease the transition into this new policy and to alleviate whatever confusion it may generate, Council directed the Department of Communications to develop guidelines for writers and speakers on the use of non-gender-specific language.

The Department used the following resources in compiling this report:

The American Medical Association's Manual of Style.

The American Psychological Association's Guidelines for Nonsexist Language.

The Handbook of Nonsexist Writing, Second Edition, by Casey Miller and Kate Smith.

Gender-neutral. Non-gender specific. Non-sexist.

Whatever you call it, the issue has been generating heated debate for years. In one corner are the traditionalists, sticking firmly to their belief that the generic "man" or the generic "he" refers to all people, male and female. In the other corner, a growing number of people who for a variety of reasons — a desire for fairness or clarity, or the instructions of an editor — are striving to rid their language of gender bias.

If you are a member of the OSMA who wishes to write or speak in its behalf, you now fall into the latter category. But don't despair. It isn't as difficult as it may sound. Below are some helpful suggestions on ridding your language and writing of sexual bias. Remember, as of January 1, 1990, it is OSMA official policy.

The American Medical Association's Manual of Style has this to say about sexist language: "The objectivity of science lends itself to language usage that recognizes neither sex as preeminent. However, problems frequently exist for authors and editors in determining appropriately neutral terminology. The editors of AMA publications support the use of sex-neutral language where appropriate, but that does not mean sex should never be specified. Sex can be designated when discussing a

specific person or whenever pertinent. The careful writer and editor should select terms that avoid bias, suit the material, and do not intrude on the reader's attention."

Of course, that's the tricky part. Over the years, various solutions have been offered, among them the creation of common-gender pronouns (e.g., "s/he," "shem," "shim," "himorher"). Most experts now agree that these creations emphasize the problem without really solving it. Today, there are several generally accepted ways to resolve the problem.

As an example, take the sentence "The patient is usually the best judge of value of his treatment." Obviously, reference to "his" makes this sentence gender-specific when it shouldn't be. To turn it into a non-gender-specific sentence you could take one of at least four approaches:

1. Deletion of the gender specific word. "The patient is usually the best judge of the value of treatment."
2. Adding the other gender to balance. "The patient is usually the best judge of his or her treatment."
3. Changing the sentence to plural. "Patients are usually the best judges of the treatments they receive."
4. Rephrasing the sentence. "The best judge of the value of treatments is usually the patient."

Obviously, the his or her, he or she, him or her options can get to be wordy and monotonous if used repeatedly. In lengthy speeches or articles, you may want to use all four approaches. In an effort to avoid both gender-specific pronouns and awkward sentence structure, some forward-thinking grammarians advocate the use of plural pronouns with singular indefinite antecedents. An example, "Everyone calls (note singular verb) their (instead of his or her) pediatrician at night."

If you can adopt this approach without the specter of some long-past English teacher rising up to haunt you, fine. Speaking on behalf of the staff of *OHIO Medicine,* we find we can't. We prefer rephrasing. For example, you could opt for "Everyone calls the pediatrician at night" or "People call their pediatrician at night."

All of the above are problems of designation, in other words, how you designate by sex the persons referred to in the sentences. But there are other problems when striving for non-sexist language. One major problem is stereotyping. For example, take the sentence, "Workaholic physicians often neglect their wives and children." By referring to "wives" this statement implies that all workaholic physicians are men. A better way to express this thought is "Workaholic physicians often neglect their spouses and children."

Likewise, problems arise with the designations "woman doctor," "lady lawyer," or "male nurse." Unless the speaker or writer believes that specifying the sex of the individual is necessary, "doctor," "lawyer" or "nurse" is all that is needed.

Finally, on the subject of the "girls" in the office, this too is sexist stereotyping. Unless the women who are being referred to are, in fact, under age 18, they are not girls. A more proper and more professional designation would be receptionists, secretaries, office assistants, etc.

If this entire article leaves you with the feeling that the staff of *OHIO Medicine* is a group of women libbers, we would like to point out two facts: First, these changes will take a minimum of effort and will result in a publication and official pronouncements that more accurately reflect the membership makeup of the association. Second, just for the record, the proper designation for women's libber would be feminist or supporter of the women's movement.

— *Carol Wright Mullinax*

A vocabulary for non-sexist authors

Are you looking for ways to avoid sexist writing? Printed below are some of those words you'll want to omit the next time you're submitting a manuscript to the OSMA . . . as well as words you can use instead.

Of course, if you're stuck, the *OHIO Medicine* staff will be happy to help you out. We've had lots of practice finding just the right word . . .

Businessmen: Business people
Chairman, chairwoman: Chair, head, presider, presiding officer, convener, leader, moderator, coordinator.
Congressmen: Representatives, congressional representatives, members of Congress, Congress people.
Forefather: Ancestors, forebears.
Gentleman's agreement: Unwritten agreement, agreement based on trust.
Laymen: Lay people, laity
Man, mankind (meaning the human species): Human beings, people, we, us
Man (meaning person): Person, one, individual, you, I
Man (as verb): Operate, work, staff, serve at (or on or in)
Man-hours: Work-hours, labor time
Man of letters: Literary person, writer, author, pundit
Manpower: Personnel, staff, human resources, labor, people power, muscle power
Middleman: Contact, go-between, intermediary, agent
One-upsmanship: The art of one-upping
Right-hand man: Chief assistant, lieutenant
Spokesman: Spokesperson, representative
Sportsmanlike: Sporting
Workman: Worker
Workmanlike: Efficient, skillful

Communications committee meets, plans future projects . . .

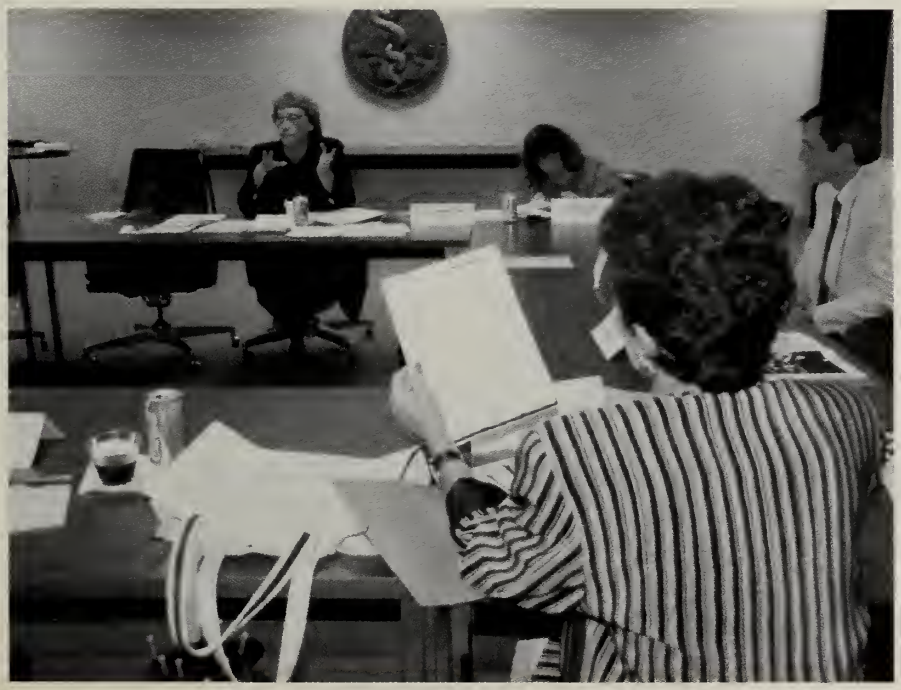
The committee's student members John Kennedy, Columbus, and OSMA-MSS President Cindy Smith, Fairhaven.

Carol Wright Mullinax, Director of OSMA's Department of Communications, reviews the meeting's agenda with Communications Committee Chair William Dorner, MD, Akron.

Committee members William Kose, MD, Findlay and Nino Camardese, MD, Norwalk.

Committee members Susan Hubbell, MD, Lima; John W. Thomas, MD, Wooster; Patty Whisman, MD, Newark.

Other OSMA committees convene . . .



Above, left: Charles D. Cobau, MD, Toledo, who co-chairs the OSMA Committee on Cancer, meets with Robert D. Clinger, Director of OSMA's Department of Medical Society and Member Relations, prior to the meeting.

Below, left: OSMA's Task Force on the Homeless, chaired by Judith S. Daniels, MD, Cincinnati, covered a full agenda at its recent meeting.

Above, right: Charles R. Smith, MD, Canton, confers with Donald A. Senhauser, MD, Columbus, during a recent meeting of OSMA's Committee on Government Relations and Third-Party Payors.

One Call Can Make You Both Feel Better.

1-800-548-KIDS

You may have seen patients like Terry. He's one of 160,000 children in Ohio whose hard-working families are barely making ends meet...they can't afford doctor's visits, but don't qualify for government assistance. When these kids get sick, they don't get the care they need until they're so sick they wind up in the hospital. It's a senseless tragedy for these children.

And it's a tragedy that you can help stop. In only a few hours a month, you can help Ohio's uninsured children get the basic preventive care they need, such as check-ups, vaccinations, outpatient services and prescription drugs.

This is possible through The Caring Program, a non-profit, charitable foundation endorsed by the Ohio State Medical Asscciation and the Ohio Chapter of the American Academy of Pediatrics. Funds to provide coverage and compensate physicians for their services are provided by private donations and are matched dollar for dollar by Community Mutual Blue Cross & Blue Shield.

Join "The Caring Program For Children."

Many Ohio physicians have already signed up to participate. But we need you. Please join us, as a partner in The Caring Program, and help make Ohio's physician network as large as possible. If you have received a "Caring Program" package, just mail in your contract, or call 1-800-548-KIDS (872-6800 in Cincinnati) for information. Today, make the call that matters.

Caring Program for Children

The Caring Program is endorsed by the Ohio State Medical Association and the Ohio Chapter of the American Academy of Pediatrics.

COMMUNITY MUTUAL
Blue Cross Blue Shield
THE STRENGTH TO LEAD

Editor's Note: This summer, the AIDS Activities Unit of the Ohio Department of Health issued a report on a survey it had conducted of physician attitudes toward the treatment of persons with AIDS and the HIV virus. An edited version of this report appears below.

Physicians' Attitudes Toward Treating AIDS: How Does Your Attitude Measure Up?

The demographics

The ODH sent out 150 surveys, designed to assess physician attitudes toward treating AIDS. Of the 150 questionnaires mailed, 77 were returned. From that number, the following demographic picture was drawn:

- 83% were male; 17% female
- 21% were between 30-39 years; 17% were 40-49 years; 16% were 50-59 years;
- 44% were 60 years or older.
- Two physicians were between 20-29 years.
- 29% practiced in Hamilton County
- 42% were in general practice; 55% in specialty practice

Treatment policy

Since the survey was designed to gain a measure of attitudes toward treating patients with AIDS, a number of questions focused on treatment policy. When the respondents were asked if, to their knowledge, they were currently treating a patient with AIDS or a patient infected with the HIV virus, 79% indicated that they were not, while 20% indicated that they were. In general, it appears that those doctors who did treat AIDS patients were younger than those who did not. Almost 31% of the women respondents were currently treating patients with AIDS/HIV infection in contrast to 18% of the men. Only a slightly higher proportion of physicians in specialized practice indicated that they treated AIDS patients or persons who were HIV positive.

Thirty-one percent of the respondents indicated that they would prefer not to treat individuals infected with HIV or at high risk of infection. For those physicians under the age of 40, 17% would prefer not to treat. Only one female respondent (8%) preferred not to treat in contrast to 38% for male respondents. Fifty-five percent felt that people

Doctors below the age of 40 and the female respondents were more inclined to feel they could effectively treat a person with AIDS.

infected with HIV or who have AIDS would best be treated by AIDS experts as a specialized medical center. In general, the younger doctors were more inclined to hold this opinion although 56% of the respondents 60 and older were similarly inclined. Only 42% of the females were inclined toward treatment at specialized facilities in contrast to 60% of the male physicians.

When asked to check the procedures for which the respondents and their staff currently wear protective gloves, they indicated the following:

- 53% used gloves when drawing blood
- 62% used gloves when changing dressings
- 22% used gloves when giving injections
- 3% used gloves when taking vital signs
- 27% used gloves when treating "high-risk" patients

In general, the younger respondents and female respondents are more inclined to use gloves when drawing blood and giving injections than were the older and male physicians. Giving injections appears to be a reason for wearing gloves for only 22% of the respondents with no apparent differences between age group and sex. Only two respondents indicated the use of gloves for taking vital signs.

Another indication of the physician's awareness of the problems associated with treating AIDS patients or persons infected with the HIV virus is their use of procedures as precautions against spreading infection among health-care workers. When asked to choose between preference for specific infection control practices and universal body fluid precautions, 64% would prefer not to use universal blood body fluid precautions.

In terms of the respondents having been tested for antibodies to HIV, only 13% reported doing so. One reported contact with an AIDS patient as a reason for taking the test for HIV antibodies, and another reported contact with bodily fluid other than blood as a reason for testing. Nine selected "other" as a reason for testing, with a number of these respondents indicating that it was for insurance purposes. Seventy-seven percent of the respondents had never had a test for HIV.

Attitudes toward treatment

In general, the respondents felt that they had adequate knowledge to protect themselves when treating an individual with AIDS or who is infected with HIV virus. Over two-thirds of the respondents indicated so, but the younger respondents were slightly more inclined to believe so than the other age groups. Respondents from the 40-49 year age group were the least likely to feel confident based on a mean of 2.3 as compared to the other three groups all with means below 2.0. Also, the variance for this age group was considerably higher, indicating a wider range of responses. Male and female differences were slight, but females were more confident in their ability to work with these patients. Here again, it is important to remember that the female respondents to this survey were younger than the male respondents.

Having knowledge to treat these patients is viewed in the same manner by the respondents. The older respondents (60 and older) are more likely to feel that they do not have the knowledge to treat these patients than the younger respondents. In fact, doctors below the age of 40 and the female respondents were most inclined to feel that they could effectively treat a person with AIDS or having the HIV virus.

Respondents from all the age groups and from both sexes tended to disagree with the statement "I am concerned about my patients changing physicians if it is known that I treat people who have AIDS or are infected with HIV." Younger respondents tended to disagree with this notion more than the older group of physicians. However, 26% of the oldest respondents did not respond to the statement. Clearly, the older the respondent, the less likely that he/she would disagree with this statement. Males were somewhat less inclined to strongly disagree with this statement than females.

When the respondents

considered testing for antibodies to HIV at regular intervals, there was a good amount of uncertainty. Although the younger physicians were slightly more likely to disagree with the need for regular testing, all age groups were clustered toward the median position. Females were also inclined to disagree with the need for regular testing and were less likely to deviate from their mean response of 2.3 than were the male respondents.

This same pattern of response held true for staff fears about treating patients with AIDS. The younger respondents were less likely to be concerned about staff fears than older physicians. There was very little difference between male and female respondents to this question.

Education and training of staff

Each respondent was asked to select from a list of steps taken to educate their staff about AIDS. Below are the items that were provided on the survey form:

- 49% had distributed articles about AIDS
- 18% had sent staff to educational conferences
- 43% had distributed pamphlets on AIDS
- 10% had brought in a speaker
- 16% had done none of these activities

Among the "other" response specified by the physicians, the most frequently mentioned was some form of staff conference/discussion. One mentioned TV and other programs as a source of education and another mentioned inservice programs.

Another question asked the respondent her/his top three preferences as a means for learning about AIDS. The physicians responding to this survey learn more about AIDS and HIV infection from seminars and conferences than by any of the other means listed (58%). The second most widely used medium were medical and health journals (29%). Local and state health departments were an important source of information, but only 9% of the respondents indicated this to be their first or second choice. Another source of information is the respondent's colleagues or peers. While 31% of the respondents chose this as a medium important enough to rank, only 11% indicated it as their first or second choice.

Finally, the physician was asked to select from a list of subjects for inclusion in an AIDS educational program. It is very clear from reviewing their responses that physicians are most interested in educational programs that enhance their ability to effectively treat AIDS patients and/or persons infected with the HIV virus. The fact that diagnosis was the item receiving the highest response (42%) indicates that many of these physicians desire assistance in this area. In addition, risk assessment (21%) and clinical treatment (20%) would be important topics to cover in any attempt to provide AIDS education programs. Providing training in the area of psycho-social issues, referral services and infection control, while not among the first choices of the respondents, were nevertheless important for these people. Twenty-eight percent selected psycho-social issues as one of their three choices while referral services were of priority for 42%, and infection control for 35% for the respondents. A few other items mentioned by the respondents were economic concerns and the epidemiology of AIDS.

Conclusion

Of crucial importance in considering the responses to the various items included in the survey has been the age and sex of the respondent as well as, in some instances, whether the respondent is in general or private practice. In general, it seems that older physicians are less knowledgeable about how to treat than are the younger respondents. Yet, they are not as conservative as one might think. In general, they felt that their reputation would not be damaged if they treated AIDS patients or persons infected with the HIV virus.

Of major concern is the representativeness of this survey. While it is clear that no attempt was made to draw such a sample, until such a sample is drawn we will not have a clear picture of what physicians know about AIDS, their approach to treatment, and, among other things, their need for new information and resources. **OSMA**

Editor's desk . . . *continued*

Medi-scene" section this month. Please review it, especially if you are thinking about writing or contributing an article, as *OHIO Medicine,* as well as OSMA's other publications, will be observing and enforcing the gender-neutral policy beginning January 1.

From *OHIO Medicine,* the Department of Communications, and all of the staff here at the OSMA, season's greetings, and all the best wishes for the coming year.

Karen S. Edwards

Legislature Focuses on Health-Care Issues

Legislative Update, 1989

By the OSMA Department of Legislation

Health care has retained its status as the most popular topic of legislation during the first year of the 118th Ohio General Assembly, which began in January, 1989 and will run through December, 1990. The OSMA legislative staff has identified more than 100 bills with a potential impact on physicians and patient care. The OSMA Committee on State Legislation, chaired by Herman I. Abromowitz, MD, of Dayton, has discussed and taken policy stands on more than 40 of these legislative proposals. From health insurance to faith healing, from AIDS to workers' compensation, medical liability to mammography, the OSMA has been aggressively pursuing physicians' concerns on a broad array of issues that are being debated before the Ohio Legislature.

While the volume of issues at the Ohio Legislature is growing, the political leadership of the Ohio General Assembly has remained constant as majority parties in both houses were returned to power following the 1988 elections. The Ohio House of Representatives is led by Speaker Vern Riffe, a Democrat from Wheelersburg, serving in an unprecedented 15th year as speaker. The Democrats continue firmly in control of the House with a majority of 59 seats to the Republican minority's 40. In the Ohio Senate, Republicans are in control by a vote of 19-14. State Senator Stanley J. Aronoff, a Republican from Cincinnati, was elected president of the Ohio Senate, succeeding Paul E. Gillmor, who was elected to Congress. Both Speaker Riffe and President Aronoff have, on many occasions, lent their considerable assistance to resolve the concerns and problems that OSMA and its physicians have addressed to the Ohio Legislature.

With so many health-related issues on the legislative agenda, Ohio physicians must be prepared to assist the OSMA in representing the views of organized medicine. As in past years, the 118th General Assembly does not count among its 132 legislators a single physician. Accordingly, it remains our charge to educate Ohio legislators about the issues that are important to physicians and their patients.

On the following pages is a brief description and status report on selected legislation that is currently pending before the Ohio General Assembly. Some legislation has passed and is now state law, while other bills will remain pending until the curtain closes on the 118th session of the Ohio General Assembly next December, 1990.

Mandatory Medicare Assignment

Again this year a bill mandating that physicians must accept Medicare payment as payment-in-full for services provided to Medicare patients has been introduced into the Ohio House of Representatives. Introduced by Representative Barbara Pringle of Cleveland, House Bill 235 is similar to the Massachusetts

version of mandatory assignment in that Ohio physicians would be in danger of losing their medical license for repeated violations. House Bill 235 has been referred to the Ohio House Health and Retirement Committee where two hearings have been held on the bill. Hundreds of physicians and their spouses have already written their state representative to oppose House Bill 235. More physician letters are needed to defeat the bill because senior citizen groups are also generating volumes of mail in support of House Bill 235.

AIDS

After two years of debate the Ohio General Assembly passed the omnibus AIDS bill, Senate Bill 2, and it became effective on November 1, 1989. Sponsored by state Senator David Hobson of Springfield and state Representative Paul Jones of Ravenna, Senate Bill 2 is a comprehensive approach to the AIDS epidemic. Some of the issues it addresses are: testing, both confidential and anonymous; informed consent to be given prior to testing; special disclosure to health-care workers about patients' HIV status if there is a medical need to know; mandatory and confidential reporting of positive HIV tests to health officials; state-directed programs for care and education of high-risk groups; a new state program to encourage nursing homes to offer care to AIDs victims; and prohibitions against discrimination against AIDS victims by life and health insurers. For more information on how Senate Bill 2, the new AIDS law, affects physicians and their office staffs, please refer to the separate article in this issue of *OHIO Medicine.*

The OSMA worked diligently with legislators to assure that the final version of Senate Bill 2 reflected physicians' wishes as expressed by the 1989 OSMA House of Delegates. We believe physicians should be pleased with the final version of Senate Bill 2. The OSMA wishes to thank the many physicians who participated in the legislative process on Senate Bill 2, many of whom testified before the Ohio Legislature. We also wish to thank Senator Hobson and Representative Jones whose perseverance made this significant law possible.

Medical Liability

Senate Bill 246, sponsored by Senator Robert J. Boggs of Jefferson, would establish a new standard to be applied by a physician in determining when to obtain informed consent for a treatment or procedure. The standard currently applied by Ohio courts requires a physician or other health-care provider to advise a patient about any material risks associated with a treatment or procedure if a "reasonable patient" would refuse the treatment once advised of the risks. In Senate Bill 246, this standard would be changed to require that a physician advise a patient of any material risks and obtain informed consent to a treatment or procedure if he or she suspects that such information would cause that particular patient to decline the treatment. As a result, if this new standard is adopted, any patient who suffers a complication or an unexpected side effect would be able to bring suit against the physician alleging that if the potential side effect had been known, he or she would have foregone the treatment. OSMA believes Senate Bill 246 would pose a significant liability problem to physicians.

Senator Richard C. Pfeiffer, Jr. of Columbus has introduced legislation, Senate Bill 251, to give physicians who provide voluntary health-care services to indigents a qualified immunity from tort liability. When health care is provided to people below a certain income level without expectation or receipt of any type of payment or reimbursement, a physician will be subject to liability only if his or her actions constitute willful or wanton misconduct. This qualified immunity is designed to afford some protection to physicians treating individuals in homeless shelters. OSMA supports Senate Bill 251 and will be working to expand the immunities afforded to physicians under certain circumstances.

OSMA also supports a third bill addressing physician liability issues, House Bill 354, sponsored by state Representative Vermel Whalen from Cleveland. This bill would provide qualified immunity to physicians who report to a patient's employer that the patient is using a controlled substance if the patient's employment involves the operation of any aircraft, train, bus, taxicab or other types of common carrier. This immunity would only apply in situations where the patient's use of the controlled substance presents a potential risk of harm to passengers.

On a related issue, Senate Bill 197 remains pending in the Ohio Senate Health and Human Services Committee. This legislation, introduced by State Senator David Hobson of Springfield at the request of the OSMA, would afford a physician who is adversely affected by a peer review decision the right to petition the court of common pleas for a substantive review of the case, findings and actions taken by the hospital. Currently, Ohio courts will review peer review decisions only on limited, procedural grounds. The OSMA feels that the creation of a right to a substantive appeal to the courts is necessary to ensure the effectiveness of the peer review process and to protect the rights of both the physician against whom an action is taken, and the members of a peer review committee.

Durable Power of Attorney for Health Care

You will now be able to

OSMA Federal Key Contact Program

At the start of 1989, the OSMA established a new Federal Key Contact Program to develop and coordinate Ohio physician participation in the federal legislative and regulatory process. Funding for this pilot project was provided by the AMA, which awarded Ohio one of two grants to implement such a program. The other grant recipient was the state of Pennsylvania.

The new Federal Key Contact Program is designed to keep Ohio physicians and their spouses better informed and more involved in federal developments that affect organized medicine. This is accomplished through creation of a grass-roots system of personal contacts between physicians, their spouses and members of Congress.

Since its inception, the program has embarked upon a number of new projects utilizing the efforts of many Ohio physicians. Each such project has been tailored to the needs or desires of the participating physicians and spouses, as well as to address specific issues with which the U.S. Congress has been involved. One type of project developed under the Key Contact Program involves establishing personal relationships with members of Congress through local visits by physicians and spouses. This approach facilitates easier and more direct communication between organized medicine and federal lawmakers as issues arise that affect the medical profession.

A second program that has met with much success is a single-day Washington fly-in trip. On these excursions, physicians and their spouses fly into Washington D.C. in the morning for a full day of meetings with congressional members and other health-care policymakers. Participants then return home in the late afternoon or evening of the same day.

In addition to these organized events, a second goal of the Federal Key Contact Program is to keep Ohio physicians and auxilians informed about pertinent federal legislation under consideration in Congress. A new feature in the OSMA's monthly *Legislative Bulletin, Fednotes,* highlights such key federal issues and current congressional developments.

Of particular importance to physicians in Ohio and throughout the country is the outcome of the budget reconciliation process, which proposes a variety of physician payment reforms designed to curb growth in the federal Medicare program. Budget reconciliation measures have been under consideration in two committees of the U.S. House of Representatives, and a committee of the U.S. Senate. The House Ways and Means Committee approved a package of physician payment reforms that includes national Medicare expenditure targets, implementation of RBRVS, and a ban on balance billing in excess of 115% of the RBRVS payment schedule. Also included in the version approved by the Ways and Means Committee are provisions of the so-called "Stark Bill," H.B. 939, which would prohibit physician referrals to medical facilities, such as laboratories, in which the referring physician has an ownership interest. This proposal is in conflict with a budget reconciliation package approved by another House committee, Energy and Commerce, which contains neither the provisions of the Stark bill, nor expenditure targets but does provide for implementation of a budget-neutral RBRVS beginning April 1, 1990 and a limit of 120% of the RBRVS fee schedule for balance billing under maximum allowable actual charges.

In the Senate, the Finance Committee continued work throughout mid-October on its version of a budget reconciliation package. Among the proposals it was considering was development of non-binding Medicare volume performance standards as part of a new data monitoring system to track Medicare expenditures without resorting to the more drastic expenditure targets. The Senate proposal also includes provisions for annual updates of the conversion factor and a floor precluding fee rollbacks in the annual update. Like the House Energy and Commerce Committee, the Senate version does not incorporate the Stark ban on referrals.

Reconciliation between the differing versions of the federal budget was required by October 16th in order to avoid triggering the automatic, across-the-board cuts in programs under the Gramm-Rudman-Hollings deficit reduction act. In Medicare, such cuts would total 2%. The entire reconciliation process has been closely followed by AMA Washington lobbyists seeking to mitigate the most damaging of the physician payment reforms. This is clearly an area upon which the attention of Congress is focused and one that illustrates the need for an effective federal key contact program such as the one developed in Ohio.

The OSMA encourages all physicians and spouses to take advantage of this opportunity for involvement in government operations at the federal level. Any questions about the program should be directed to Kathy Wehe, coordinator of the Federal Key Contact Program at the OSMA. — *Kathy Wehe, coordinator, Federal Key Contact Program*

designate another person as your "attorney in fact" to make health-care decisions for you if you are unable to make them for yourself. Senate Bill 13, sponsored by state Senator Richard C. Pfeiffer, Jr. of Columbus, passed the Ohio General Assembly this June, following almost 15 years of debate on this issue, and became law on September 27, 1989. The bill authorizes the creation of a durable power of attorney for health care as one means of assuring that a person's wishes regarding health care are followed even when he or she is no longer capable of expressing them. For more information on Senate Bill 13, please refer to the article on durable power of attorney in this issue of *OHIO Medicine.*

Health Insurance

There is growing sentiment among public policymakers that something needs to be done to make affordable health insurance available to the escalating number of Ohioans who are medically uninsured. When coupled with a plea from some members of the business community for government to impose a national health insurance plan as a means of controlling health-care costs, the pressure for reform of the correct system is significant.

A bill to adopt a Canadian-style health-care plan in Ohio has been proposed by state Representative Robert Hagan of Youngstown. House Bill 425 would create the Ohio Universal Health Insurance Plan to provide every Ohio citizen with basic health insurance coverage. Private insurers would be prohibited from competing with the Plan for the provision of this basic coverage. The state-run Plan would be funded by levying a series of taxes on the income of wage earners and employers and by scuttling Medicare and Medicaid in Ohio and redirecting those funds to the Plan. One hearing on the bill has been held in the Ohio House Insurance Committee. As one would expect, House Bill 425 has gathered a great deal of opposition from the health insurance industry, the OSMA, and other health-care providers. (For more information on House Bill 425, please refer to the separate article on "Should Ohio Adopt the Canadian Health Plan?")

In response to the problem of providing affordable health insurance to the medically uninsured, the Ohio General Assembly passed House Bill 24 this year. Sponsored by state Representative Ray Miller of Columbus and state Senator David Hobson of Springfield, House Bill 24 creates a grant program within the Ohio Department of Health with funding awarded to communities that propose projects that will provide affordable health insurance to certain employed but uninsured workers. House Bill 24 is now law, and the Department of Health has selected projects to receive grants in these cities: Canton, Cincinnati-Dayton, Columbus and Cleveland. Physicians in these communities are urged to assist the health-care demonstration project in their community. For more on House Bill 24, please refer to the separate article in this issue of *OHIO Medicine,* "Can the Private Sector Find Solutions?"

The Ohio Legislature is also on the verge of passing another bill to address a segment of the medically uninsured population. House Bill 188, known as the "state risk pool" bill, has passed both the Ohio House and the Ohio Senate and now resides in a joint House-Senate conference committee. This

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Should Ohio Adopt the Canadian Health Plan?

A bill pending in the Ohio House of Representatives would abolish existing private health insurance, Medicaid and Medicare and replace them with a state-run health system, similar to that in operation in Canada, which would cover all Ohioans. Introduced by state Representative Robert Hagan of Youngstown, House Bill 425 currently resides in the Ohio House Insurance Committee. Even the sponsor, Representative Hagan, concedes that House Bill 425 is not going to pass soon, but it has sparked much discussion and debate. The OSMA opposes House Bill 425.

The leading advocate for a Canadian health system in Ohio is Ohio Citizen Action (formerly Ohio Public Interest Campaign or OPIC), a Nader-style consumer group. Ohio Citizen Action (OCA) stresses the need to make health insurance universally available, and says that a government-run program will spend less on administrative costs than is spent by private insurance companies. It is not clear how physicians or other health providers would fare under House Bill 425, but OCA's goals are readily apparent. This same group has promoted mandatory Medicare assignment legislation, currently House Bill 235, and also opposed OSMA's effort to pass medical liability insurance reform in 1987.

The Ohio Department of Insurance provided OCA with a forum to extol the Canadian system when it conducted a series of hearings througout the state in September of this year. In Youngstown and Cleveland, OCA turned out a string of witnesses and supporters, who were very vocal with both complaints and demands. At every hearing physicians provided testimony to articulate the practitioner's perspective on the issue of availability of health insurance. The OSMA extends its gratitude to all the physicians who testified, and to the county medical society executives who arranged for physician testimony.

At the conclusion of these hearings, the superintendent of the Ohio Department of Insurance will appoint a "blue ribbon" task force to examine the evidence presented at the hearings and submit a report. The OSMA will be actively involved in the task force's deliberations.

In the General Assembly, House Joint Resolution 29 would create a legislative task force to study the availability of health insurance and access to health-care services. The task force would be composed of legislators, providers, insurers, consumers and representatives of business and labor. HJR 29 has passed the Ohio House and awaits action by the Senate.

Can the Private Sector Find Solutions?

Four communities will be conducting state-directed experiments to see whether they can make affordable health insurance available to uninsured workers. State Representative Ray Miller of Columbus and state Senator David Hobson of Springfield sponsored the authorizing legislation (House Bill 24) that created a health-care demonstration project grant program within the Ohio Department of Health. Each community demonstration project is to be designed to assist some segment of the uninsured population receive health insurance. The four projects that have been awarded the state grants are listed below:

- Coalition for Cost-Effective Health Services, Columbus. This project will provide private managed medical care through an HMO to individuals and their families who have recently left the public assistance rolls due to obtaining employment, but whose employers don't provide health insurance coverage. Employees will contribute to the cost of HMO coverage on a sliding fee scale based on income with grant funds providing the difference.
- Federation for Community Planning, Cleveland. This project is to establish a low-cost health benefits plan emphasizing preventive care through an HMO. Premium costs will be shared by the employer, worker and the state through the grant funds. The employee contribution will be on a sliding scale based on income.
- Stark County Health-Care Coalition, Canton. This project will provide a limited, low-cost benefit package through a self-insured plan. Premium costs will be divided among the employer, worker and the grant funds. Health services will be provided at reduced rates through a Preferred Provider Organization and local hospitals.
- United Way of Greater Cincinnati, Cincinnati-Dayton. This project is to cover 14 counties in southwestern Ohio. Two self-supporting trusts will be established to administer the "Individual/Family Health-Care Account." Participating employers will contribute a monthly amount per employee. The program includes catastrophic health insurance for costs of more than $10,000, medical spending accounts that would reimburse enrollees for the cost of basic health services, assistance in securing financing from or through providers for uncovered costs, a review process, and consumer and employer education.

Many physicians and county medical societies already are participating in their community's demonstration project. The OSMA urges physicians to assist in making these projects succeed in their community. — *OSMA Department of Legislation*

Legislature Enacts Durable Power of Attorney

Senate Bill 13, sponsored by Senator Richard C. Pfeiffer, Jr. of Columbus, allows for the creation of a durable power of attorney for health care as a means of ensuring that an individual's wishes regarding the use of discontinuation of life-prolonging measures will be heeded.

The durable power of attorney for health care is the first step taken by the legislature to address the issue of prolonging the life of terminal patients by mechanical or artificial means, despite the patient's or family's desire to discontinue or withhold such treatment. This follows over 10 years of debate on the emotional issue by proponents and opponents of the living will concept. While Senate Bill 13 does not authorize the creation of a living will (in which an individual would expressly state his desires about life-prolonging procedures), it does provide for the designation of a surrogate decision-maker empowered to make most health-care decisions including the withholding or withdrawal of life-prolonging measures. Effective September 27, 1989, Ohioans will be authorized to execute documents in which they designate another individual to make health-care decisions on their behalf when they are incompetent or otherwise unable to make such decisions on their own.

The new law contains a number of immunity provisions requested by the OSMA. In essence, **a physician will be immune from criminal prosecution, civil liability or professional discipline for acts taken in good faith, and in reliance upon health-care decisions made by an attorney in fact (the person named as surrogate decision-maker) if all of the following are satisfied:**

a. the decision is made by an attorney in fact after he or she receives sufficient information to satisfy the requirements of informed consent, and the physician in good faith believes that the attorney in fact is authorized to make the decision;
b. the physician in good faith believes that the decision is consistent with the desires of the patient, or if such desires are unknown, the decision is in the patient's best interest; and,
c. if the decision is to withhold or withdraw health care necessary to keep a terminal patient alive, the physician attempts, in good faith, to determine the desires of the patient and places a report of the attempt in the medical records of the patient.

In addition, **a physician will not be subject to criminal prosecution, civil liability or professional discipline if he or she, for moral or ethical reasons, is unwilling or unable to comply with the directions of an attorney in fact to withhold or discontinue life-sustaining measures.** In such situations, however, a physician may not prevent or attempt to prevent the transfer of the patient to another physician who is willing to comply with the instructions of the attorney in fact.

Under a durable power of attorney for health care, the attorney in fact can make most health decisions that could be made by the patient if he was competent. A person executing a durable power of attorney for health care may, if he or she so chooses, include specific limitations on this power. In addition to any limitations contained in the document itself, the following are statutory limitations on the powers of the attorney in fact:

a. decisions to discontinue or withhold life-sustaining treatment can only be made when the patient is in a terminal condition;
b. comfort care cannot be refused or withdrawn;
c. life-sustaining treatment cannot be withheld or withdrawn from a pregnant patient unless the pregnancy is threatening to her life or two physicians determine that the fetus would not be born alive;
d. nutrition and hydration cannot be refused or discontinued unless two physicians determine that they would not provide comfort to the patient and either that death is imminent and the lack of nutrition or hydration would not result in death by malnutrition or dehydration, or if provided, nutrition or hydration would shorten the patient's life, or could not be assimilated; and,
e. consent cannot be withdrawn for treatment the patient previously consented to unless the patient's physical condition has changed or the treatment is no longer effective.

With regard to executing a durable power of attorney for health care, the new law allows for the use of a preprinted form that can be completed without the involvement of a lawyer. The OSMA has developed a brochure and form for use by patients in considering or executing a durable power of attorney for health care. This form permits the patient to legally name someone to make medical decisions for him or her should they become incompetent. The OSMA will provide all members with a supply of these brochures entitled, "Health Care Decisions: Who Makes Them When You Can't?", free of charge to distribute to patients. — *OSMA Department of Legislation*

bill would create a state insurance pool from which Ohioans who are unable to obtain health insurance because of medical conditions that make them a poor insurance risk can go to purchase health insurance coverage. The OSMA supports House Bill 188, and OSMA's legislative staff has worked with the bill's sponsor, state Representative Mark Guthrie of Newark, toward its passage.

The Ohio House of Representatives has passed House Bill 554, which would require every family insurance policy to cover preventive health services for children from birth to age 18. Strongly supported by the Ohio Academy of Pediatric, House Bill 554 is sponsored by state Representative Paul Jones of Ravenna. The bill has been assigned in the Ohio Senate to the Financial Institutions and Insurance Committee.

Another bill that has passed the Ohio House would require health insurance policies to cover infertility diagnosis and treatment with certain limitations and exclusions. House Bill 138, sponsored by state Representative Michael Shoemaker of Bourneville, has also been referred to the Ohio Senate Financial Institutions and Insurance Committee.

A bill to require that health insurance policies cover a schedule of mammography screenings has been recently introduced in the House of Representatives. House Bill 642, sponsored by state Representative Helen Rankin of Cincinnati, is awaiting assignment to a committee to begin the hearing process.

In response to these several bills mandating certain health insurance coverages, the chairman of the Ohio House Insurance Committee, state Representative Mike Stinziano of Columbus, has introduced a bill for prior review of any new mandated benefits legislation. House Bill 568 would create the Mandated Health Benefits Review Commission to evaluate the social and financial impact of mandated health insurance legislation. House Bill 568 is being heard by the Ohio House Health and Retirement Committee.

A new law creating an Ohio Life and Health Insurance Guaranty Association will assess Ohio insurers to pay for the claims of the insureds in the event that an insurance company goes bankrupt. House Bill 89, sponsored by state Representative Mike Stinziano of Columbus, takes effect on November 20, 1989. A similar measure dealing with the solvency of insurance plans would require health maintenance organizations (HMOs) to demonstrate financial viability. The sponsor, state Representative Wayne Jones of Akron, says House Bill 593 will provide important consumer protection for HMO contract holders, establish new financial solvency requirements for HMOs and streamline the regulation of HMOs within the Ohio Department of Insurance. House

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The New AIDS Legislation: How It Affects You and Your Office Staff

The new Ohio AIDS law, which became effective on November 1, 1989, encompasses a wide range of issues such as testing, counseling and reporting the disease. Sponsored by State Senator David Hobson of Springfield, Senate Bill 2 was reported to be one of the most comprehensive AIDS bills in the nation. Physicians will undoubtedly have questions about how the new law will affect them. Below is a brief overview of the law as it applies to practicing physicians. If you have additional questions, please direct them to the OSMA Department of Legislation.

1. **Informed Consent/Pre-Test Counseling.** The following information must be given to an individual prior to testing for HIV:
   a. An oral or written explanation of the test and testing procedures, including the purposes and limitations of the test and the meaning of its results;
   b. An oral explanation that the test is voluntary, that consent to be tested may be withdrawn at any time before the individual tested leaves the premises where blood is taken for testing, and that the individual or guardian may elect to have an anonymous test; and
   c. An oral or written explanation about behaviors known to pose risks for transmission of HIV infection.

In addition, the Ohio Public Health Council, pursuant to recommendations of the Director of the Ohio Department of Health (ODH), is required to promulgate rules specifying the information to be given an individual before he or she is tested. (The OSMA will keep members updated regarding this hearing process.) A minor may consent to be given an HIV test. However, parents or guardian of the minor giving consent are not liable for payment for an HIV test given to a minor unless they give their consent.

Exceptions to Informed Consent. Informed consent statutes do not apply in the following situations:

a. When the test is performed in a medical emergency by a nurse or physician and the test results are medically necessary to avoid or minimize an immediate danger to the health or safety of the individual to be tested or another individual (counseling is to be given to the individual tested as soon as possible after the emergency is over);
b. When the test is performed by or on the order of a physician who, in the exercise of his or her professional judgment, determines the test is necessary for providing diagnosis and treatment to the individual to be tested, if the individual or the individual's parent or guardian has given consent to the physician for medical treatment.
c. When an infection control committee of a health-care facility or other body performing a similar function of a health-care facility determines that a health-care provider, emergency medical services worker or peace officer, while rendering health or emergency care to an individual, has sustained a significant exposure to the body fluids of that individual and that individual has refused to be tested.

2. **Post-Test Counseling.** Post-test counseling is now required by law. The tested individual must be given an oral or written explanation of the nature of AIDS and AIDS-related conditions and the relationship between the HIV test and those diseases, and a list of resources for further counseling or support.
3. **Test Results.** Test results are confidential. However, besides being released to the individual tested or his or her legal

guardian, the law does allow release to others as stated below:

a. The results of an HIV test or the identity of the individual on whom the HIV test is performed or who is diagnosed as having AIDS or an AIDS-related condition may be released to the individual's spouse or "any sexual partners";
b. HIV test results may be released to a health-care provider, emergency medical services worker or peace officer who has sustained significant exposure to the body fluids of the tested individual. However, the identity of the individual tested is not to be revealed;
c. Anyone who the tested individual (or his or her legal guardian) specifies in writing to receive the results;
d. The individual's physician;
e. The ODH or health commissioner or local health authority to which AIDS reporting is mandatory;
f. Other health-care providers or an authorized agent or employee of a health-care facility or health-care provider, if the provider, agent or employee has a medical need to know the information and is participating in the diagnosis, care, or treatment of the individual on whom the test was performed or who has been diagnosed as having AIDS or an AIDS-related condition.

4. **Reporting of Results.** Ohio law requires that all confirmed positive HIV results be reported to the ODH or local health department.

For more information, please contact the OSMA Department of Legislation.

Bill 593 has been referred to the Ohio House Health and Retirement Committee.

A bill making insurance fraud a crime and setting strict criminal penalties for violators, House Bill 347, has been the focus of a number of appressive amendments offered by health insurers in an effort to control the practice of medicine. The OSMA has successfully opposed amendments to make physicians subject to crimes for overutilization, kickbacks, and waiver of copayments. House Bill 347 has passed the Ohio House and is undergoing hearings in the Ohio Senate Financial Institutions and Insurance Committee.

Limited Practitioners

Groups of limited practitioners continue to press the Ohio General Assembly for expansion of their statutorily defined scopes of practice. In Senate Bill 104, optometrists are seeking the legal right to apply therapeutic drugs in the treatment of eye disease. The Ohio Ophthalmological Association and the OSMA oppose Senate Bill 104 arguing that physicians, not optometrists, are educated and trained to make medical diagnoses. Senate Bill 104 has had two hearings before the Ohio Senate Health and Human Services Committee.

Physical therapists are asking for the right to practice independently without a physician referral. House Bill 227 passed the Ohio House over the OSMA's objections and has been referred to the Health and Human Services Committee in the Ohio Senate. This same Senate Health Committee has heard opposition testimony from an OSMA witness on House Bill 55 which would add chiropractors and podiatrists to the list of those who may be appointed county health commissioner.

Another limited practitioner group, psychologists, is seeking a law that would prohibit discrimination by hospitals when considering applications for medical staff privileges or membership. House Bills 268 and 499 have received several committee hearings in the House of Representatives and are opposed by both the Ohio Psychiatric Association and the OSMA.

In House Bill 599, physician assistants are seeking their own licensing board and enhanced practice authority. In House Bill 523, radiation technologists are seeking to establish a licensure requirement and create a new licensing board. Both bills are under consideration by the Ohio House Health and Retirement Committee. In an effort to stem the number of newly licensed health occupations, state Representative Judy Sheerer of Shaker Heights has introduced House Bill 587 creating an Allied Health-Care Licensing Advisory Commission. The OSMA supports House Bill 587 because the concept of establishing a separate commission to evaluate the public need for additional health-care licensure has succeeded in other states to slow the growth in licensing these limited practitioners.

Under current law, **the director of the Ohio Department of Health** must be a physician but the governor wanted to eliminate this requirement in an amendment to House Bill 552. Justification offered for the proposed change was the difficulty experienced by his administration in finding a physician to take the position. The OSMA persuaded the Ohio Senate Finance Committee to restore the physician requirement.

Ohio's workers' compensation system was reformed under House Bill 222 to add oversight to the system's operation and to clarify agency roles. As originally proposed, House Bill 222 appeared to be a serious attempt by the Bureau of Workers' Compensation to set health-care provider fees, but the OSMA together with other provider groups persuaded

legislators and business and labor to agree to recognize usual, customary and reasonable fee structures.

In House Bill 332, **Ohio's Certificate of Need program** (CON) was revised and extended until November 15, 1991. The dollar thresholds that trigger CON review were increased from $1 million to $2 million for capital expenditures; from $500,00 to $750,000 for operating expenditures; and from $750,000 to $1 million for medical equipment.

A new state law prohibits the sale, manufacture or possession of **drug paraphernalia.** State Representative John Boehner of West Chester sponsored House Bill 182, which received OSMA support and testimony from medical students Larry Frick of Cincinnati and John Kennedy of Columbus.

Some progress was made to reduce legal exemptions for **spiritual treatment** or faith healing when the Ohio Legislature gave courts the power to order medical treatment for children whose parents refuse to do so for religious reasons. House Bill 257, sponsored by state Representative Paul Jones of Ravenna, who is strong advocate for complete elimination of spiritual exemptions, also requires to be reported in any case of child abuse or neglect that results from a parent's failure to seek proper medical attention for his or her child.

House Bill 420 would impose a temporary moratorium on permits to construct **infectious medical waste** treatment facilities. Supported by OSMA House of Delegates policy, House Bill 420 has passed the Ohio House and now resides in a Senate committee. At the same time, the Ohio EPA is now in the process of promulgating rules to define the proper methods of disposing of infectious medical waste. The Ohio EPA action is in response to a new Ohio law, House Bill 243, which passed the Ohio General Assembly last year.

Health care has been and will remain one of the most legislated and regulated areas of law for the foreseeable future. The OSMA legislative department follows a huge volume of legislation, roughly 10% of all bills introduced in the Ohio General Assembly affecting physicians. We hope that this article, the OSMA *Legislative Bulletin,* and other publications will stimulate physicians and their spouses to speak directly with their local legislators about these issues.

The OSMA Department of Legislation is composed of Director John Van Doorn, Cynthia Snyder, Chris Robinson and Betsy Schiffman.

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The 13th Annual Business Session of the Resident Physicians Section

Editor's note: *The following material came from "Code Blue," an AMA/RPS supplement containing news for resident physicians that's included in each month's issue of* **Resident and Staff Physician.** *This article, on the 13th Annual Business Session of the AMA's Resident Physician Section, which took place in June, has been edited to meet space requirements.*

Over 200 residents from 33 states, 17 specialty societies and all four uniformed services represented their peers at the 13th Annual Meeting of the AMA Resident Physicians Section (AMA-RPS) Assembly in Chicago in June. The AMA-RPS provides a national forum for residents' concerns, and through the AMA House of Delegates, influences organized medicine's policymaking. The AMA-RPS Assembly meets twice a year immediately prior to the AMA House to deliberate on reports and resolutions of interest to residents. Items that call for AMA action are then submitted to the AMA House for consideration.

While resident work hours was the most pressing issue facing the section at the meeting (see sidebar), positive action on a variety of issues was taken as a result of activity at the 1989 Annual Meeting. The following is a summary of those actions.

Options for Pregnant HIV Seropositive Women asked the AMA to (1) reaffirm policy to educate and screen women at high risk for AIDS; (2) reaffirm efforts to counsel pregnant women at high risk for AIDS of all the medically appropriate alternatives to them; and (3) support government funding of all medical services that are deemed appropriate by both the patient and physician for pregnant seropositive women lacking other sources of funding. This resolution will be sent to the AMA House of Delegates for consideration at the 1989 Interim Meeting in December.

Service Recognition asked that the AMA-RPS formally acknowledge the gratitude of the profession for the work of retiring U.S. Surgeon General C. Everett Koop, MD.

Tobacco Advertising in Minority Neighborhoods asked the AMA to: (1) recognize that the targeting of tobacco advertising toward minorities should be curtailed; and (2) commend the efforts of other concerned organizations in their attempts to curb such advertising. The AMA House will consider the resolution at its 1989 Interim Meeting.

Fetal Drug Syndrome asked the AMA to evaluate current research in fetal drug syndrome as well as its prevention, treatment, legal implications and potential areas for expanded research. The AMA House adopted this resolution.

Reporting of Actions Against Resident Physicians on the National Practitioner Data Bank called on the AMA to work to promulgate changes in the Health Care Quality Improvement Act of 1986 that would disqualify actions taken against resident physicians for acts committed while actually working in a residency training program and not as an independent contractor, provided such actions were not the result of willful or wanton misconduct. The AMA House referred this resolution to the Board of Trustees.

Third-Party Payment for Experimental Therapeutics and Procedures called on the AMA to request appropriate agencies to encourage insurance companies, HMOs and other third-party payers to make their beneficiaries aware of their policy limitations regarding experimental procedures. The AMA House referred this resolution to the Board of Trustees.

Encouraging Health Activism by Physicians called on the AMA to encourage all physicians to participate in educational activities designed to help physicians incorporate the techniques of primary prevention and health promotion into their daily practices. The AMA House will consider the resolution at its 1989 Interim Meeting.

Residency Stress Management called on the AMA to (1) develop a resident physician wellness guide to address the many factors involved in managing and reducing resident stress, which includes descriptions of model programs in stress management; (2) urge state medical societies to develop stress management and stress reduction programs for primary prevention; and (3) inform residents of stress reduction programs in different residency programs through the AMA Fellowship and Residency Electronic Interactive Database Access (AMA-FREIDA). The AMA House referred this resolution to the Board of Trustees for action.

Mandatory Helicopter Flight for Residents in Training asked that the AMA urge residency training programs that require helicopter transport as a mandatory part of their residency to notify applicants of that policy prior to and during the interview process and that the AMA-RPS study and report on issues regarding helicopter and other modes of patient transport as they relate to residency training. The AMA House adopted this resolution.

Violence Management in Training Hospitals called on the AMA to (1) request its commissioners on the Joint Commission on the Accreditation of Healthcare Organizations to strongly urge the Joint Commission to increase compliance with its requirement to provide physicians and other health-care personnel with training for dealing with violence, especially in residency training hospitals, and to consider the

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AMA Board to Act on ACGME Mandated 80-Hour Limits

During its 13th Annual Business Session in June, the AMA-RPS adopted a resolution calling for the AMA Board of Trustees to urge the Accreditation Council for Graduate Medical Education (ACGME) to implement specific work hour reforms for all specialties in the "General Requirements" of the *Essentials of Accredited Residencies in Graduate Medical Education.* The AMA House of Delegates referred the resolution to the Board of Trustees for action, and the Board is expected to act on the resolution *before the end of the year.*

The resolution asks the AMA Board to urge the ACGME to limit residents' on-duty hours to 80 hours a week, and to limit overnight call in the hospital to no more than once every third night. So far, in the ACGME's specialty-specific accreditation system, only two specialties (internal medicine and emergency medicine) have adopted limits of 80 hours or less. The 80-hour limit was also implemented by New York state for virtually all residents on July 1.

The original resolution, introduced to the AMA-RPS Assembly by the Massachusetts delegation, called for a 90-hour limit, but the Assembly changed it to 80 hours. In recognition of significant opposition to the resolution among AMA delegates, AMA-RPS leaders asked for referral to the Board for action rather than outright adoption by the AMA House. The House referred the resolution to the Board for action by a margin of only nine votes.

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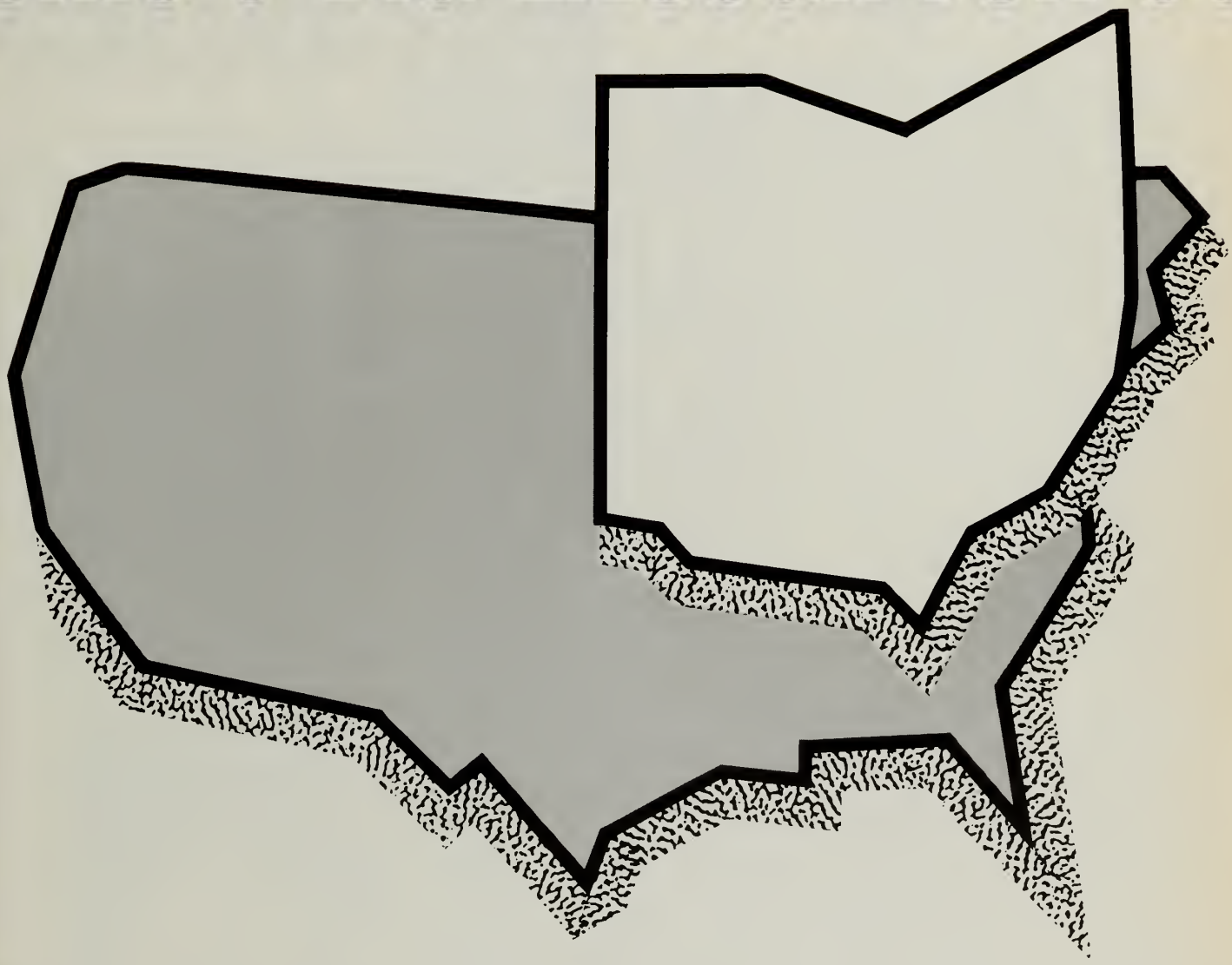

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Teleconference Is Annual Meeting Highlight

Accreditors should be doing more to reform residents' working conditions, AMA-RPS members told panelists who discussed residents' working conditions at the AMA-RPS Annual Meeting in June. The panel was part of a teleconference, "Cost of Resident Physician Work Hour Regulations: Rhetoric vs. Reality," which was broadcast live over the Hospital Satellite Network.

AMA-RPS members expressed their concerns to J. Lee Dockery, MD, a panelist who has been involved in drafting reforms within the Accreditation Council for Graduate Medical Education (ACGME). The ACGME has been criticized for excusing some specialties from making any substantive reforms. According to Dr. Dockery, the degree of flexibility included in some ACGME standards protects "all parties involved, including residents, the specialty and the profession."

However, Bertrand Bell, MD, a New York City physician who oversaw the drafting of New York state's reforms, disagreed. He said, "I suspect that most of the people who talked about flexibility were people who in their heart of hearts didn't want to get this done, and one of the ways to defeat it would be by using the term flexibility." Dr. Bell also argued that concerns that hour limits would disrupt continuity of care were a smokescreen for those who did not want reforms.

Dr. Dockery also conceded that some of the requirements drawn up for each specialty by the Residency Review Committee (RRC) in that specialty are not specific regarding resident work hours and supervision. However, he said, "in those cases where they haven't been specific, they have inserted very friendly language for the first time." Critics of the RRC guidelines say that specificity is necessary to bring about true reform.

AMA-RPS members also strongly disagreed with a study coauthored by another panelist, Timothy Deaconson, MD, and published in the *Journal of the American Medical Association* last fall, that concluded that residents' skills are not adversely affected by long hours of sleep deprivation.

"We are not saying a problem doesn't exist, but simply that we find no sleep deprivation-induced deficit," said Dr. Deaconson. When several delegates rose to question him about the study and its results, Dr. Deaconson said most questions were answered in the manuscript. He expressed disappointment at the response to his study, and called for others to duplicate the study using its scientific method rather than complaining about results.

Some AMA-RPS members took issue with another panelist, Elizabeth Sommers of the Greater New York Hospital Association, who criticized her state's radical new rules on residents' hours and supervision, which took effect July 1. Sommers noted that "I do not want regulation in print, but flexibly enforced," saying that would, in effect, create a standard of practice. She also said some residents in later years of training would have to be brought up to 80 work hours to cover for those first-year residents whose hours are cut to 80 by the regulations.

possibility of requiring 24-hour armed security guards in emergency room settings, where appropriate, to search for and confiscate weapons and (2) report back on Joint Commission progress toward the goal of increased compliance with its requirement to provide violence training and toward providing security in hospital emergency rooms at the 1990 Annual Meeting. The AMA-RPS referred this resolution to the Governing Council for study.

HIV Home Test Kits asked the AMA to recommend to the Food and Drug Administration that it not approve Human Immunodeficiency Virus (HIV) home test kits. The AMA House will consider the resolution at its Interim Meeting in December.

RU 486 asked that the AMA Board of Trustees study the effectiveness of the drug RU 486 (Mifepristone) as a safe alternative to surgical abortions and report back by the 1989 Interim Meeting, and that the AMA encourage Food and Drug Administration approval for RU 486 if it is found to be a safe alternative to surgical abortions. The AMA-RPS referred this resolution to the Governing Council for study.

Loan Deferment During Residency asked that the AMA-RPS prepare a detailed report of AMA activities regarding medical student loan deferment during residency and make recommendations for further policy for consideration at the 1989 Interim Meeting. The AMA-RPS adopted this resolution. **OSMA**

COUNTY COLLECTION

The Medic Man Encore

Ross D. Martin, a third-year student at the University of Cincinnati's College of Medicine couldn't resist the temptation to poke a little fun at the profession he is soon to join. Turning to Meredith Wilson's time-honored "The Music Man" for inspiration, he took pen in hand and finally finished his good-natured spoof, "The Medic Man," in time for the UC Medical Student Talent Show, where it was performed as the show's finale this past April.

If the entertainment industry has taught us anything, however, it's that good shows (well, at least money-making shows) never die . . . they're reprised, and such was the case this September when the Cincinnati Academy of Medicine invited the students to do an encore performance as the entertainment portion of its 133rd Annual Meeting.

The show is explained as Martin's and the medical students' gift to families, friends and the medical community . . . a gift, as the advertisements say, that keeps on giving.

Below are scenes from the performance for Academy members.

What about a review of the show? Well, just suffice it to say that we think Meredith Wilson — and probably Harold Hill, himself — would have been pleased. — *Karen S. Edwards*

Professor Peter Pill ("The Medic Man" 's writer-producer Ross Martin) dances with Madam Anatomist (Denise Richey).

Martin and pal Marscellus Walker (Matt Warner) left contemplate an escape route.

County Collection . . .

Dr. Hahnel named Outstanding Woman Physician by Women's Medical Association of Cleveland

A Cleveland family practice physician has received the Outstanding Woman Physician Award from the Women's Medical Society of Cleveland. Germaine Hahnel, MD, was recently honored with the award in recognition of her more than 30 years of medical service.

The award, which is presented to honor a physician who has served as a role model for other physicians, took Dr. Hahnel by complete surprise. "Maybe (they chose me) because of my diverse practice," she says. "I started out in private practice, then became residency director at Fairview, and now I'm working with a geriatric home. Being involved in the community" probably didn't hurt either, she adds.

Edith Vangelista, MD, president of the society, says that Dr. Hahnel was chosen precisely because of her active participation in medicine.

"A committee is formed," to consider candidates for the award, says Dr. Vangelista. "We look to someone . . . who's been active in medicine . . . (and) Dr. Hahnel has been very active."

Adds Kathryn Popowniak, MD, chairman of the committee that selects award winners, "Dr. Hahnel had been at the Family Practice Program at Fairview General for a number of years and was a very good teacher and a very good role model." She was selected for "her devotion to medical practice."

Dr. Hahnel, who graduated from the University of Cincinnati in 1957 and has been practicing medicine since 1959, says selecting the medical field for her profession was not a difficult choice. "I always enjoyed taking care of cuts and bruises, doing first aid," she recalls. Plus, "I had asthma as a child so I had to go to physicians a lot."

The decision to become a family practitioner, however, did not come as easily.

"I really liked everything," says Dr. Hahnel, "and I had a hard time deciding what I wanted to do."

A residency in internal medicine eventually convinced her to return to family practice. "I missed the OB, the kids," she says, adding that she's never regretted her decision.

"I really enjoyed taking care of the whole family," she says. "You get to know everyone . . . over a period of time you really get to know your families."

Having practiced medicine for 30 years, Dr. Hahnel says she has noticed some changes in the profession, especially where women are concerned. "There were only two other women in my class at medical school," she says, out of a class of 90 students. "The year before, there were two, and years before that there were none.

"And now, by contrast, (classes) average about 40% women." When Dr. Hahnel was a student in the late '50s, she continues, "There were certain specialties that were taboo to women — you never saw women in orthopedics — but now I don't think there are any barriers."

Germaine Hahnel, MD . . . outstanding woman physician.

In addition to her private practice, Dr. Hahnel, a native Clevelander, also served as the director of the family practice residency program at Fairview General Hospital from 1975 to 1986. Today she is the medical director of the new Renaissance Health Care Center — a retirement community — and of the Malachi House for homeless terminally ill patients. — *Michelle J. Carlson*

Master carver back at work . . .

Former OSMA President Lawrence Meredith, MD, who carved the OSMA logo that not only graces the OSMA's reception area at its headquarters building in Columbus, but each of the association's annual meetings, recently presented the Lorain County Medical Society with its own plaque, on which he had carved the county society logo. John Secrist, MD, (left) president of the Lorain County Medical Society, accepts the handiwork from Dr. Meredith.

Columbus medical society executive retires

James S. Imboden retired as executive director of the Academy of Medicine of Columbus and Franklin County as of September 1, 1989. Imboden assumed his duties in March 1974 as executive director and proved to be a visionary leader in developing new innovative Academy programs during his 15-year tenure. During this time he has developed the Academy into a strong community force with extensive involvement with both the coalition of cost-effective health care and health check, a local preventive medicine program. A mini-internship program also developed, resulting in an excellent opportunity for informational exchange and better understanding of mutual problems between physicians and other community and business leaders. He has established excellent relationships with the Hospital Association of Central Ohio and maintained strong relations with the Ohio State Medical Association and the American Medical Association.

During Imboden's leadership, the Academy has grown from a small county society employing

James S. Imboden

two people to a complex business entity employing 57 staff members. He was the major force in developing a strong for-profit division to support the Academy of medicine. This organization, Physician Service Corporation (PSC), has grown into a complex structure which includes Academy Medical Personnel Services (AMPS) and The Columbus Medical Bureau, which offers excellent answering and collection services. Also included in PSC is an automotive services division, which provides both automobile leasing and buying options to physicians and their staff. An insurance division has been developed, and multiple discount arrangements with local companies have been developed to benefit physicians. Imboden was instrumental in the development of Physician's Health Plan (PHP). This HMO-IPA has become a major force in providing health insurance to Central Ohio, providing patients free choice in physician and hospital utilization. PHP has now converted into a for-profit organization with the Academy as the major stockholder, and has expanded to offer health insurance to a large part of Ohio.

Through monies derived from PHP, the Academy has been able to begin funding an Academy Educational Foundation to provide educational programs to the Central Ohio community and supply grants for community projects, further enhancing physician involvement and leadership in Central Ohio.

A native of Omaha, Nebraska, Imboden was born September 27,

County Collection . . .

Columbus medical society executive retires . . . *continued*

1926. He graduated from Central High in St. Joseph Missouri. He attended St. Joseph's Junior College receiving an Associate in Science Degree in June 1948. While at St. Joseph's, he was elected student body president and served as sports editor of the school paper and was president of the Newman Club. He graduated in 1950 from Washburn University in Topeka, Kansas and attended Kansas State University in Manhattan, Kansas where he did graduate work in education. Imboden served two years with the U.S. Navy as a Pharmacist's Mate and was stationed at Bremerton Naval Hospital, Bremerton, Washington.

Before moving to Columbus, Imboden was assistant executive director of the Kansas Medical Society for six years, where he worked with 22 of the 44 committees of the society.

In 1965 he came to Columbus to establish a field office for the American Medical Political Action Committee (AMPAC). From 1965 through 1974 he was the AMPAC field representative for Ohio, Illinois, Indiana, Kentucky and West Virginia, serving as consultant to state medical political action committees and individual congressional and senatorial campaigns. During his years with the Academy of Medicine, Imboden has remained a loyal friend to the physician members of the Academy as well as medicine in general. He has been an excellent counselor for the presidents of the Academy, helping the local Academy become actively involved at the state and national levels of organized medicine.

Despite his active role in developing new projects and overseeing the Academy growth, Imboden has been able to support the development of the "family" atmosphere at the Academy office. He has never been too busy to be interested and listen to concerns and problems of the staff, whether professional or personal. In addition to his active schedule with the Academy, Imboden has served the community as an active Rotarian. He also has been actively involved with the First Community Church of Upper Arlington.

We at the Academy, both physicians and staff, will miss his insight, his calm and thoughtful approach to problems, his wit, and his expertise on solving Academy issues. As executive director emeritus, we expect him to be available as a consultant to assist us in solving some of the issues yet to come.

We all wish he and his wife, Joan (Jody) the best in their years of retirement. We hope they will have extra time to enjoy their family, especially their grandchildren, as well as the travel and hobbies that had to be postponed because of Academy commitments. Best wishes for a long and happy retirement. — *Owen E. Johnson, MD*

Telling medicine's story

Banking, law and politics may not seem to have much in common, but for one day last July those diversified fields came togehter — in the doctor's office, the hospital and the operating room. The unlikely meeting came as a result of Lake County Medical Society's first mini-internship program, during which eight "interns" from various fields shadowed Lake County physicians for a day to learn more about the medical profession. From 7 a.m. until 8 p.m. (and, in some cases, longer), interns endured patient examinations, hospital rounds, surgery and endless paperwork.

"I wasn't sure why I agreed to participate in the program," says Ronald J. Patterson, vice president of Ameritrust in Painesville, "(but) after having spent the day with Dr. (Arthur) Martin, I felt it is an experience to be appreciated for a lifetime. Not often does a lay person have the opportunity to take a candid, honest look into the medical profession."

According to Jan Vargo, the society's executive secretary, Patterson's comments are typical of the interns who participated. Prior to the internship, she says, several of the interns questioned the relevancy of the internship to their own lives. "It was a remarkable friendship that came up, what a change among the

people" from their first meeting, Vargo says. "They have a one-on-one relationship now."

The idea for the internship came from societies that had already tried similar programs. In fact, says Vargo, the society purchased the basic program from the Cincinnati Academy of Medicine, then modified it to suit their needs.

"It gave us an idea of how to schedule," she says, adding that "we worked with only one hospital, so that went really well." After the basics were in place, society President Janet Blanchard, MD, handpicked member physicians to participate. (Specialties that were represented included anesthesiology, cardiology, plastic and reconstructive surgery, and internal medicine.)

"I picked people who are enthusiastic (about medicine)," says Dr. Blanchard. "There are some people who like to teach, who like to show others what they do. They're extremely positive about Lake County medicine."

Meanwhile, potential interns were solicited in the community "who were 'user-friendly,' who wouldn't blow us out of the water our first time out," says Vargo. "We picked people we knew would have an open attitude toward us." (She is quick to add, however, that one intern was an attorney, a professional that is often portrayed as being an adversary to the medical profession. He was so impressed with the program, she says, that he is trying to create a similar program for his bar association in an effort to dispel myths the public often has about the law profession.)

The program was scheduled for a Monday in July, Vargo says, because the participating physicians agreed that it would likely be busy and provide the interns with a good look at the practice of medicine. Instead, she says, "It was a dead day. Nothing. It was the deadest day, so I don't think anyone got called out in the middle of the night." (Interns had previously agreed to shadow their respective physicians for 24 hours, in case emergencies arose.)

Ronald J. Taddeo, MD, a plastic and reconstructive surgeon who participated in the program, agrees that the day was unusually slow, but points out that a "slow" day for a physician can seem like a marathon to a lay person.

"We had a full office day with a bit of hospital duties," says Dr. Taddeo, who chaperoned the Rev. Robert Schuler. "The pace is what impressed most interns, how fast-

Building a one-on-one relationship during the Lake County mini-internship program were: Bobbi J. Popover, MD; Susan Cannon; Frank Roy; and Steven P. Combs, MD.

County Collection . . .

Telling medicine's story . . . *continued*

paced it is, how unscheduled it is — we had 10 minutes for lunch — (whereas) I would say most interns have nine-to-five, well-defined jobs." Whereas some interns spent most of the day in surgery, that is only one aspect of medicine, says Dr. Taddeo. "The thrust of this activity was to put this lay person in the doctor's shoes as much as possible . . . and they saw not just clinical problems, but family problems, problems related to finances."

The cost of health care, in fact, is one aspect that Dr. Taddeo would like to see be addressed more during future internships. "In general, when you hear about the costs of medicine," you blame the physician, he says. The interns, many of which probably have to select health insurance programs for their employees "will be told (the high costs are) because of these damn doctors you're paying high rates to. Those are the people who would be educated."

In fact, he says, interns might be surprised to learn that "the doctor is often called upon to bend or eat the difference (of health-care costs), to smooth out the problems."

Dr. Taddeo is so concerned that interns learn the whole side of medicine's story that he has suggested that during next year's internship (one is tentatively planned for next summer) they spend one full day in a clinical setting and one half-day dealing solely with the business side of medicine.

If it sounds as though the day was a success, you're right. In fact, the only problem the society encountered was a lack of interest on behalf of the local media. "What we tried to do was to include our local media (to cover) the medical community (in a situation) that is favorable," says Vargo. Unfortunately only one young reporter showed up for a dinner that followed the day-long event, "so that's the only place we failed," she says.

But overall, everyone agrees, the program ran extremely well for a first-time endeavor. "(The interns) thought it was wonderful," says Dr. Blanchard. "I think they're going to have a better appreciation for what (physicians) go through on a daily basis. We do more than just take care of patients."

Adds Dr. Taddeo: "I think there's always a danger that critics would say that we pad the day, that we put on a good show . . . but this was a genuine attempt to show lay people what we're doing." — *Michelle J. Carlson*

VICE PRESIDENT FOR ACADEMIC AFFAIRS AND DEAN, SCHOOL OF MEDICINE

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The Medical College of Ohio, a free-standing institution located in suburban Toledo, Ohio, invites nominations and applications for the combined position of Vice President for Academic Affairs and Dean of the School of Medicine.

As Vice President for Academic Affairs, the incumbent is a member of the College's administrative core, responsible to the President for education and research in the School of Medicine, Graduate School and the Schools of Nursing and Allied Health. These responsibilities include interactions with affiliated teaching hospitals and other organizations, planning for capital needs, and working interactively with other administrative offices to implement the missions of the College.

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Are You a Member of the AMA?

By Katherine E. Wisse

More than 6,000 OSMA active members joined the AMA in 1989 but there are still over 5,000 OSMA members who do not belong. AMA membership is vital because it completes the picture of organized medicine and ensures representation at the national level.

Current activities of the AMA on behalf of physicians include:

Legislation:

- The AMA urged the approval of legislation banning the sale and ownership of assault weapons.
- The AMA is backing the Rural Health Incentive Act of 1989 which would offer tax incentives to physicians practicing in rural areas with shortages of health-care professionals.

Health policy:

- The AMA filed an amicus brief supporting the case of Brian Zebley, a disabled child who lost his disability benefits (due to strict Health and Human Services regulations) because of its "grave concern that the present regulations work systematically to deny poor, disabled children access to essential medical services."
- The AMA is the leading defender of patient and physician rights in the nation's courts — e.g. support for protection of AIDS patients and challenge of PRO procedures that forced the federal government to agree to due process protection for all physicians.

Public Relations:

- The majority of physicians interviewed in an AMA survey found American Medical Television (AMT) programming both informative and useful according to Nielsen Medical Research.
- The AMA's National Communications Conference (NCC) will be held in conjunction with the National Leadership Conference (NLC) in Phoenix, Arizona in February 1990. The AMA's NCC and NLC conferences will focus on the AMA's priority program to strengthen the U.S. health-care system.

Products:

- The AMA published "Practice Patterns of Orthopedic Surgeons," the second in a series of reports on selected specialty groups.
- The AMA produced the "Brief Resource Guide on Adolescent Health," the topic of which is the state of adolescent health and strategies for preventing health problems.

Professional relations:

- The AMA's Young Physicians Section has established sections in 20 specialty societies and eight state societies since its formation in June 1988.
- The AMA has experienced dramatic growth in the more established Medical Student Section, Resident Physicians Section and Hospital Medical Staff Section.

The work goes on. Facing physicians in the legislature today is the specter of ETs and Medicare changes. The AMA needs your support to meet these challenges. If you are not already a member of the AMA, join with your 6,000 Ohio colleagues who are. Call the OSMA Department of Membership Development for further details. — OSMA

Katherine E. Wisse is Director of OSMA's Department of Membership Development.

The Loss Awareness Bulletin is provided each month through the OSMA Task Force on Professional Liability and its subcommittee on Loss Awareness.

Attention to Concerns Preceding a Court Trial

While the focus of *Loss Awareness Bulletin* has been upon actions that can help lessen the risk of malpractice claims and court trials, the fact remains that many lawsuits are resolved prior to trial. For this reason, events that occur before a trial become highly significant.

The recommendations that follow may help physicians have a more positive influence in the pre-trial process.

Contact your professional liability insurer if you suspect a problem may develop

Early involvement by your malpractice insurer and legal counsel make it possible for full investigation of a potential claim — while events surrounding the claim are fresh in the minds of potential witnesses.

When a physician obtains an unfavorable medical result during a procedure, there is a possibility of a lawsuit. When a physician receives a request from an attorney for office medical records, his suspicion also should be aroused. Such actions may be forerunners of a lawsuit months or even years later. It is not realistic to assume or hope that a dissatisfied patient will not file a lawsuit. But early involvement of the malpractice insurer and legal counsel — and a fully developed defense — may help dissuade a nuisance lawsuit from progressing any further.

Charting: more important than ever

Previous editions of *Loss Awareness Bulletin* have focused on characteristics of "defensible" medical records. In today's litigious climate, charting has become an even more important concern in medical practice. Good documentation can be the physician's best defense and best ally. Should the case go to trial, the defense can be visibly strengthened when the defendant physician's records are accurate, complete and reliable.

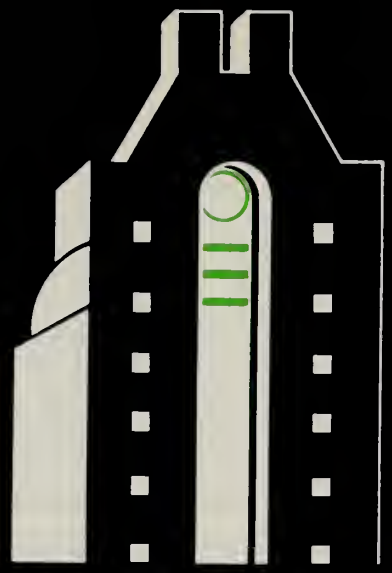
Alteration of records calls for caution

Claims files show, unfortunately, numerous instances in which a claim against a physician was medically defensible — but was lost because the physician had altered the records after receiving notification of the claim being filed.

Even the best kept medical records sometimes have an inaccurate or incomplete entry — if you discover this is the case, extreme care is required in the method of correction or addendum.

The recommended method is to draw a single line through the entry; then, a note in the margin

continued on page 978



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— indicating the error or change — should be made with the date and time of the corrected entry.

Improper corrections can lead to the suggestion of record tampering and can destroy credibility of what might have been a clearly defensible claim.

Discuss the case with no one except your legal counsel

After receiving notification of a lawsuit, defendant physicians often discuss — with a partner or associate — how the patient's case might have or perhaps should have been managed.

When it is time to give a deposition, the physician invariably will be asked if the case has been discussed with anyone. Answering honestly, the doctor soon will find that the next deposition taken likely will be that of his partner or associate.

It's advisable to discuss the case with no one except your insurer/legal counsel and your spouse. And in working with your attorney, it's important that you reveal everything, including what you perceive to be any possible weaknesses in your case. Prior knowledge of this information enables your attorney to prepare the best defense of your case.

Active involvement in your defense

Defense attorneys often are discouraged to see a physician arrive for a pre-deposition conference and sit in the office opening several weeks' worth of mail they have received from the attorney.

Information you are sent needs to be reviewed as you receive it so that you can offer your comments and explanations. On numerous occasions, defense attorneys receive from the physician a better suggestion or a medical explanation that shows why the plantiff's theories are wrong.

Anything that can be done to help in preparing the strongest possible defense can only be of benefit to the physician.

While the suggestions offered here certainly will not win every case — and nor will they make the process of litigation any more comfortable — they can possibly decrease the settlement amount. If a trial is necessary, they also may produce more favorable results for the defendant physician.

A malpractice trial is one of the most stressful experiences in already demanding medical careers, but attention to these concerns and involvement in the process that precedes the court trial can be highly important to the physician's future. **OSMA**

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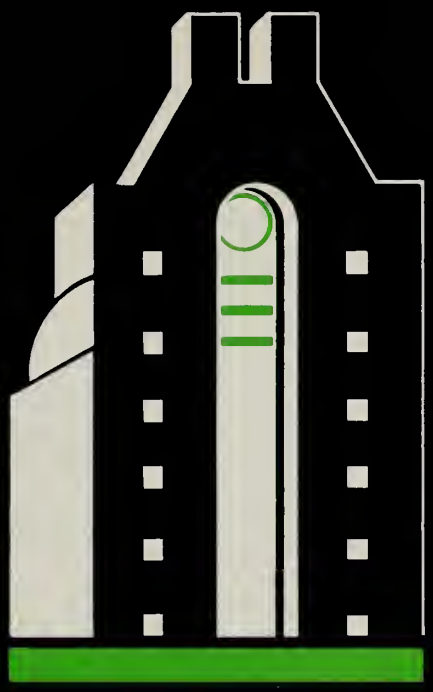

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By Alvin E. Rodin, Md and Jack D. Key

Cyclopia

(cyclopism, cyclops, monoculus, monophthalmus, monops[1])

Cyclopia is the designation for the presence of only one palpebral space in the midline, below an elongated, tubelike probiscus.[2] Cyclopia may have one or two eye globes within the single orbit; although more strictly speaking, synophthalmos is defined as two fused globes, and cyclopia the much rarer complete fusion.[3] It may be a hereditary condition. One patient and some members of his family had a missing third chromosome and a supplementary "C" chromosome.[4] These fetuses are stillborn because of related malformations, particularly of the central nervous system.

The name is derived from the Cyclopes of Greek and Roman mythology. They were referred to by Homer as a one-eyed, gigantic and lawless race of shepherds in Sicily who devoured human beings. The Cyclopes served as assistants to Vulcan, and were killed by Apollo for having furnished Zeus with thunderbolts.[5] The Arimaspians were yet another mythical people who had only one eye each. They lived in Sycthia, north of the Black Sea, and sought to steal the treasures of the griffins.[6] In African folklore, the wengwa of Gabon is a reanimated corpse which has only one eye in the center of its forehead.[7]

Cyclopia has been reported in many animals: horse, cow, pig, sheep, goat, cat, guinea pig and rat.[8] In rabbits, it may be inherited. Cyclopia may occur in fetuses of pregnant ewes which feed upon or are given the plant *Veratrum californicum* about the 14th day of pregnancy.[9] Such teratogenic activity is due to cyclopamine, a steroidal alkaloid extracted from the plant.[10] Anatomical defects include absence of one optic nerve, of the olfactory nerve, and of various small bones of the cranium and face.[11]

Quevedo y Villegas, in his 1626 book titled "Graces and Disgraces of the Eye of the Ass," likened the anus not only to an eye, but also to the Cyclopes.[12] The justification was that the eye of the "ass" is median and is only one "for so it comes to resemble the Cyclopes, who themselves were one-eyed and descended from the gods of sight."

1. OED: II:1300.
2. Kokich, V.G. et al.: Cyclopia: An anatomic and histologic study of two specimens: *Teratology,* 26:105-113, 1982.
3. Duke, E.S.: Anomalies of fusion: in *System of Ophthalmology,* 2nd ed., V. III, St. Louis, C.V. Mosby, 1964, pp. 429-451.
4. Pfitzer, P. & Muntefering, H.: Cyclopism as a hereditary malformation; *Nature,* 217:1071-1072, 1968.
5. Bulfinch, pp. 471-472.
6. Schmidt, p. 114.
7. Hill, D.: "The History of Ghosts, Vampires and Werewolves" Ottenheimer, Memphis, 1973, p. 14.
8. Saunders, L.Z. & Rubin, L.F.: "Ophthalmic Pathology of Animals" Basel, S. Harger, 1975, p. 202.
9. Bryden, M.M. et al.: Cyclopia in sheep caused by plant teratogens: *J. Anat.,* 110:307, 1971.
10. Keeler, R.F. & Binns, W.: Teratogenic compounds of *Veratrum californicum* (durand). II.: *Can J. Biochem.,* 44:829-838, 1966.
11. Gimeno, M. et al.: Malformaciones Congenitas en La Oveja: Ciclocefalos: *Anat. Histol. Embryol.,* 9:129-133, 1980.
12. Quevedo [y Villegas], F.G. de: "Graces and Disgraces of the Eye of the Ass:" 1626, as quoted by Gonzales-Crussi in "Three Forms of Sudden Death," New York, Harper & Row, 1986, p. 130.
13. Schedel, H.: "Woodcuts from Hartman Schedel" Neurenberg, 1498.

SMOKING CESSATION

Anthony J. Costa, MD

Cigarette smoking is the single largest preventable cause of premature death and disability in our society. Although the incidence of smoking has gone down in the last 20 years, it is still very prevalent among teen-agers. Several good methods of smoking cessation are available to the physician for use in his/her office. This article summarizes these methods and outlines a simple program of intervention which can be used in any primary care setting.

Cigarette smoking is the single largest preventable cause of premature death and disability in our society. It is also the single major cause of cancer mortality, accounting for nearly 30% of all cancer deaths in the United States annually. Furthermore, smoking-related health-care costs and lost productivity amount to approximately $65 billion per year.[1]

It is obvious then that cigarette smoking is a major public health problem in this country. Currently about 26% of adults and 15% of teen-agers smoke cigarettes.[2] It is the goal of the National Cancer Institute to reduce the prevalence rates for smoking in the United States by one-half by the year 2000.[3] The American Medical Association[4] and the American Academy of Family Physicians[5] have both called for a tobacco-free society by the year 2000.

Most cigarette smokers want to stop smoking. In fact, 90% of American smokers state that they would like to quit, 60% have tried at least once and 66% are concerned about the health consequences of their smoking.[6] Physicians also feel that their patients should stop smoking. Virtually 100% of physicians believe that smoking is a major health risk and that none of their patients should smoke.[7] Yet, studies consistently show that only 50% of smokers are advised by their doctors to discontinue this practice.[8]

There are several reasons for poor physician performance in this area. Most doctors feel that patients will not comply with their advice to stop smoking even if they give it. Many doctors are frustrated by patients who quit smoking for a short time, only to resume their habit. Some physicians are concerned about withdrawal symptoms in their patients, which they feel unable to adequately treat. Finally, many physicians feel that no program of cigarette smoking cessation has a high enough success rate to make it worth trying.[1,9]

A number of techniques have been tried, with variable success, to get patients to stop smoking. Among these are hypnosis, health education, acupuncture, aversive conditioning, sensory deprivation, self-help groups, payroll contracting, self-help individual kits, minimal contact, behavior modification, cigarette fading, mass media campaigns and the use of medication. Under the latter category, nicotine has been used both in the form of a gum and also transdermally. Clonidine has been used orally as well as transdermally. And lastly, citric acid has been used in an aerosol form as an aid to smoking cessation.

Hypnosis is a technique that has been used to modify behavior of many different types. It has been used with variable degrees of success in cigarette smoking cessation. The major drawback to the use of hypnosis by physicians is the need for special training and expertise. Evaluating the effectiveness of hypnosis is difficult because of the difficulty in performing controlled trials.[10]

Health education has been used as a method of promoting cigarette smoking cessation since the Surgeon General's Report in 1964 linked cigarette smoking to diseases in humans. The advantages of this intervention are that it can be delivered to a large audience, and per-patient costs are generally low. Sometimes these classes are offered free of charge through a public health department. The success rate for these programs is low, however, and the cost-effectiveness of this method is extremely low when compared to other methods.[11]

Acupuncture has been described in several studies, both in the United States and elsewhere, with variable degrees of success. The need for special physician training is the major drawback of this technique. Furthermore, controlled studies have failed to show the superiority of acupuncture over controls.[12]

Aversive conditioning has produced success rates varying from 0% to 100% in different studies. Studies that show a high success rate have had relatively short periods of follow-up. Some

Anthony J. Costa, MD, is the director of the Family Practice Residency Program at Barberton Citizens Hospital in Barberton.

studies have actually shown an increase in the rate of cigarette smoking (number of cigarettes per day) as a result of aversive conditioning.[13]

The delivery of anti-smoking messages during periods of sensory deprivation has been shown in some studies to be effective in smoking cessation. The need for special training, equipment and long periods of time (up to 24 hours per session), preclude the widespread use of this technique. Also, it has not been evaluated in a controlled fashion to determine efficacy.[14]

Self-help groups have been used commonly throughout the United States — within the community and within the work place. The long-term success rate of self-help groups is not very great. However, the ability to reach large numbers of people with minimal professional time and patient expense makes this technique useful for those physicians involved in public health or occupational medicine.[15,16] Payroll contracting, as a method of smoking cessation, has a slightly higher success rate than self-help groups used alone.[17]

Many smoking cessation kits are available for use by physicians with individual patients.[1] These can be obtained through the American Cancer Society, the National Cancer Institute, the National Heart, Lung, and Blood Institute, the American Academy of Family Physicians and the National Audio-Visual Center, among others. The success rates vary with the kit used. The major advantage of a kit is its relatively low cost and small amount of physician time necessary.

Studies have shown that minimal intervention by physicians, consisting of the advice to stop smoking, with or without the use of nicotine gum, has been successful in up to 22% of patients at six months, and 8.8% of patients at one year.[18,19] Because of the simplicity of this method, it should be employed by all physicians who choose not to use a more sophisticated technique.

Classical techniques in behavior modification have appeared frequently in the literature throughout the last 20 years.[13,14,20] Initial results are fairly good; however, long-term results may not be superior to minimal intervention. Furthermore, these techniques require specific physician expertise and a greater expenditure time per patient.

A method of smoking cessation through cigarette fading, self-recording and contracting has been reported to have fairly good success for up to two years.[21] This study involved a small group of patients, and its results need to be validated by larger studies.

Newspaper and other mass media anti-smoking campaigns have been tried in several communities.[22,23] Although the success rates are low, the number of people who can be reached is great, and the total number of smokers who stop smoking as a result of such campaigns can be significant. Local medical societies should seriously consider sponsoring such campaigns periodically in their communities.

It is now known that nicotine is an addicting drug. Nicotine withdrawal symptoms play a role in many patients in their failure to discontinue cigarette smoking. Several studies have investigated the use of nicotine chewing gum as an adjunct to cigarette smoking cessation.[24,25] In selected patients, and with proper use of the gum, this can increase the success rate of a variety of smoking cessation techniques.[26] Used without proper instruction and follow-up, however, the success rate is not better than minimal intervention. Nicotine delivered by transdermal patch has also been shown to be effective in conjunction with other smoking cessation measures, and may be easier to use than the gum.[27]

Clonidine has achieved success rates similar to nicotine gum.[28] It has the advantage of not exposing the patient to further nicotine during the treatment phase. It is available orally and by transdermal patch.[29] Like nicotine gum, it should be used in conjunction with other smoking cessation measures and follow-up.

Finally, citric acid in aerosol form has been used to simulate the tracheal sensation produced by cigarette smoke, thereby satisfying that aspect of the smoker's desire for cigarettes.[30] Although this has had some success, it has been tried in only a small group of patients. The equipment necessary for this technique is expensive and not readily available. Furthermore, it does not address the question of nicotine withdrawal.

Every physician should make smoking cessation a priority item in his/her practice. First of all, lead by example. No physician should smoke cigarettes. Every physician should have a no-smoking policy in his office and waiting room. This should include employees and patients alike. No ashtrays should be present in your waiting room and no-smoking signs should be evident. The magazines in your waiting room should be surveyed, and cigarette advertising should be "X"ed out with a red marker.

Before a problem can be addressed, it must first be identified. Physicians should ask every one of their patients if they smoke cigarettes. For those who do, cigarette smoking should be identified on the chart clearly as an active medical problem. For patients who report that they do not smoke cigarettes, congratulate them on this healthy lifestyle choice. If they have smoked in the past, or if they are teen-agers, ask them at regular intervals about their smoking practices.

For those patients who report that they do smoke, tell them that you are very concerned that this practice will adversely affect their future health. If the reason for their office visit relates to cigarette smoking, emphasize this fact. Scare tactics don't work, and one should not dwell upon the many adverse consequences of cigarette smoking. Instead, ask the patient if he wants to stop smoking at the present time, and tell him that you will help him do so. If the patient does not want to stop smoking, repeat your concern for his future health and tell him that you will ask him again at a later date. Make a note on the chart to remind yourself to do so.

The specific program of cigarette smoking cessation you choose will depend upon your own attitudes, expertise and practice situation. The American Academy of Family Physicians markets a comprehensive Stop Smoking Program which can be used conveniently and inexpensively in most offices.[31] Today, the question is not whether physicians should employ a stop smoking program in their office, but rather which stop smoking program they should employ. Even minimal intervention will be successful in 5%-10% of patients. Although this success rate seems low, it translates to 20-30 successful ex-smokers in the average family practice per year.[32] It is unlikely that the average family physician will cure in one year more than 30 patients with any other chronic disease he treats.

The cost of cigarette smoking in terms of premature death, chronic disability, human suffering and health-care expenditure is staggering. It is the duty of every physician to diagnose and treat this disease in his/her practice.

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A RETROSPECTIVE DEATH CERTIFICATE STUDY OF AIDS AND AIDS-RELATED CONDITIONS IN OHIO: 1984-1986

Albert A. Herzog, Jr., PhD
Lois Hall, MS
Robert J. Campbell, MS
Thomas J. Halpin, MD, MPH

AIDS surveillance data are used routinely to define the magnitude of the epidemic, project future case numbers, delineate risk behaviors, and to assist in health planning and resource allocation. The purposes of this study are: (1) to evaluate the effectiveness of the Ohio Department of Health (ODH) AIDS Surveillance System in Ohio from 1984 through 1986 and (2) to identify additional cases which may have been overlooked through normal case identification procedures. A review of all deaths occurring in Ohio among males between the ages 20 and 50 was conducted for several diseases and conditions commonly associated with AIDS.

Methods

This review examines death certificates obtained from the Bureau of Vital Statistics of the Ohio Department of Health based on four criteria: year of death, sex, age and disease category. The years 1984, 1985 and 1986 were chosen for study because earlier years would not have sufficient case numbers and neither the 1987 death certificate data base nor the 1987 Ohio AIDS Reporting System (ARS) was complete. Males aged 20 to 50 years were studied because, in the early years of the epidemic, the disease spread mainly in the male population in this age group.

The diseases and conditions associated with AIDS used in this study were selected based on those used in other validation studies and further clarified through a discussion with the Centers for Disease Control (CDC) in Atlanta. (See Table 1.) The list was selected to maximize the possibility of identifying any cases that might not have come to the attention of the surveillance system while still being logistically feasible.

A copy of each death certificate meeting these criteria was obtained and checked against the ARS in order to identify all matches between the list of deaths and the AIDS case records. Certificates were separated into four groups. One group was composed of those certificates with specific reference to AIDS and/or previously identified by the ARS. Another group was also composed of certificates with specific reference to AIDS but which had not been previously incorporated into the ARS. The remaining certificates were divided into those deaths occurring in hospitals and those deaths occurring in nursing homes and private residences. The latter distinction was made on the basis that it would be easier to follow deaths that occurred in hospitals because of the ongoing relationship between the AIDS Surveillance Unit and the Infection Control Practitioners (ICPs) located in hospitals throughout Ohio. In addition, no nursing homes in Ohio accepted known or suspected AIDS patients dur-

Albert A. Herzog, Jr., PhD, is a researcher for the AIDS Activities Unit of the Ohio Department of Health; Lois Hall, MS, is supervisor for the AIDS Prevention and formerly AIDS Surveillance Coordinator for the AIDS Activities Unit of the Ohio Department of Health; Robert J. Campbell, MS, is supervisor for the AIDS Activities Unit of the Ohio Department of Health; and Thomas J. Halpin, MD, MPH, is Bureau Chief of Preventative Medicine for the Ohio Department of Health.

Table 1

Ohio Deaths, 1984-1986, Among Males Aged 20-50, By Cause of Death By Year

		All Certificates					Surveyed Cases Only				
ICD Code	Disease	1984	1985	1986	Total	Percent	1984	1985	1986	Total	Percent
007.2	Protozoal	0	0	0	0	0.0	0	0	0	0	0.0
031.0	Mycobacteria	1	0	2	3	0.4	0	0	0	0	0.0
046.3	Multifocal Leukoencephalopathy	1	0	0	1	0.1	0	0	0	0	0.0
054.0	Herpes simplex	0	4	0	4	0.6	0	2	0	2	0.7
078.5	Cytomegalovirus	1	1	1	3	0.4	0	1	0	1	0.4
112.0	Candidiasis	1	1	3	5	0.7	0	0	2	2	0.7
115.0	Histoplasmosis	1	0	0	1	0.1	0	0	0	0	0.0
117.5	Cryptococcal mening.	0	1	2	3	0.4	0	0	0	0	0.0
127.2	Strongyloidiasis	0	1	0	1	0.1	0	1	0	1	0.4
130.0	Toxoplasmosis	0	0	0	0	0.0	0	0	0	0	0.0
136.3	Pneumocystis pneumonia	3	3	11	17	2.5	0	0	0	0	0.0
173.0	Kaposi's Sarcoma	5	8	13	26	3.9	1	2	7	10	3.6
191.0 -9	Neoplasm, brain	57	57	66	180	26.7	30	22	30	82	29.7
200.0	Lymphosarcoma	11	13	12	36	5.3	8	7	9	24	8.7
202.8	Lymphoma	21	39	33	93	13.8	8	28	28	64	23.1
279.1	Immune deficiency	19	48	79	146	21.7	0	0	0	0	0.0
279.2	Combined immuno def.	3	0	0	3	0.4	0	0	0	0	0.0
279.3	Unspecified immuno def.	3	0	0	3	0.4	0	0	0	0	0.0
485.0	Bronchopneumonia	17	10	17	44	6.5	11	6	11	28	10.2
486.0	Pneumonia, unspecified	23	34	49	106	15.7	12	24	26	62	22.5
Total		167	220	288	675		70	93	113	276	

ing 1984-1986 and therefore the likelihood of finding a case in such a facility was greatly reduced. Persons who died in private residences would not have medical records available to document AIDS-related conditions. (See Table 2).

Those found on ARS were not further investigated, and those deaths occurring in non-hospital settings were excluded from further study. Cases not appearing on ARS and listing AIDS as a cause of death and those others who died in hospitals constitute the groups for further review.

A questionnaire was sent to the appropriate ICP for each of the patients who died in hospitals to determine any possible connection with AIDS. Five questions were asked in order to ascertain if the case in question might be AIDS-related. The returned questionnaires were evaluated to determine if further follow-up was needed, and the previously unreported AIDS cases found through the death certificate review were investigated to determine why they had not been reported.

Analysis of Surveyed Cases

The review resulted in the identification of 675 death certificates. One hundred ninety-nine certificates were matched with cases on the ARS system and set aside. Of the remaining 476, six were cases that were identified as being AIDS cases and 139 were identified as having died in nursing homes or other residences. For the 331 remaining certificates, questionnaires were sent to the ICPs for preliminary review. Of these, 46 (14%) were not returned. Another nine (3%) were returned by the ICPs not completed because hospital records could not be located. The remaining 276 (83%) questionnaires were returned completed. (See Table 3.) A comparison of each response group was made using three variables: marital status, race and age. Differences for these three variables between those not surveyed and those surveyed was not statistically significant ($p >= .05$).

Table 2

Possible AIDS-Related Deaths Among Ohio Males Aged 20-50, 1984-1986, Initial Disposition

	1984	1985	1986	Total
Found On ARS	36	51	112	199
AIDS Not On ARS	0	6	0	6
Hospital-Based	92	111	128	331
Non-Hospital-Based	39	52	48	139
Total	167	220	288	675

Table 3

Comparison of Demographic Characteristics Ohio Deaths, 1984-1986 (Marital Status, Race and Age) Among Males 20-50 Years of Age, w/Possible AIDS Indicative Causes of Death

	Number Response	Marital Status (% Married)	Race (% White)	Age (Mean Age)
Found On ARS	199 (29%)	8%*	72%*	35.1*
AIDS Not On ARS	6 (1%)	33%*	67%*	37.3*
Not Surveyed	139 (21%)	62%	85%	40.0
Surveyed:	331 (49%)	59%	86%	37.2
Not Returned	46 (14%)	61%	89%	38.7
Not Found	9 (3%)	67%	67%	44.9
Returned	276 (83%)	59%	86%	36.7
Total	675			

*significant difference with other groups.

Those diagnosed as having AIDS were significantly different than the other groups. Those known AIDS cases were, for the most part, not married, less likely to be white, and on average two years younger than those surveyed and almost five years younger than those not surveyed. The list of conditions and diseases that were selected not only provides the best possible chance to identify any cases of AIDS which might not have come to the attention of the surveillance system, but also provides a means of comparing the surveyed and non-surveyed groups as well as a means of clarifying differences in demographic characteristics. (See Table 1.)

While many diseases represented on the table contributed no cases to those surveyed, the more frequently reported categories are well represented in the survey sample. Certificates listing 279.1 are not among those surveyed, as all were found on ARS, as were 76% of certificates listing *pneumocystis carinii* pneumonia (PCP). Four remaining PCP cases died outside a hospital and were not surveyed. Other frequently listed codes appear among those surveyed in reasonable proportions. For these diseases, there are only slight differences in the proportions between the entire set of certificates and those actually surveyed. Fifty-nine percent of those who were not surveyed (data not shown) were diagnosed as having neoplasms of the brain as compared to 29.7% for those surveyed. This condition may not require acute care as provided in a hospital. In addition, the presence of a larger proportion of brain cancers in the group that was not surveyed may explain the higher mean age as victims of brain cancer are likely to be somewhat older.

Cases Suggestive of AIDS

Of the 276 records returned in the hospital survey, 11 cases were identified as having conditions suggestive of AIDS based on a review of each returned questionnaire. Each of the 11 cases identified as suggestive of AIDS was reviewed in still further detail. One was initially returned with both a study survey form and a completed CDC AIDS case report form thus giving fairly complete information and requiring no additional follow-up. Follow-up telephone calls were made to the respective ICPs to further review the remaining 10. Each ICP was asked for more information including the patient's AIDS risk history, whether there had been a history of any other sexually transmitted

diseases, and more specific details pertaining to the disease progression. In addition, each was asked if any HIV tests had been performed and if blood samples were still available.

Statements made by the ICPs regarding the original reason to suspect AIDS varied considerably, but many reported night sweats, fever, cough and weight loss. However, when additional information from the ICPs was obtained and reviewed there was very little further evidence to suggest that any of the 11 actually had AIDS. Most of the symptoms were likely the result of the stated conditions as recorded on the death certificate. In addition, six out of the 11 cases had had blood tested by ELISA for HIV and were reported as being ELISA negative. Of the others, four died before the test was available and another died in the emergency room before the test could be given. Unfortunately, no blood was available for further testing on any of these 11 individuals. There was also no indication of any other sexually transmitted disease in any of the 11 and in none of the cases was there a valid indication of risk group.

In the final analysis, none of the 11 cases fit the case definition for AIDS as defined by the CDC. This conclusion is reached even after attempting to fit the cases into the 1987 definition revision and again consulting with CDC staff.

Cases Diagnosed as AIDS but Unreported

A review of the six cases designated as AIDS but not reported revealed that four were diagnosed out of state, and came back to Ohio to receive care. One died in a Veterans' Administration hospital, where we were unable to trace the origin of his diagnosis. One simply was not reported, even though he was an Ohio resident and treated at a hospital that regularly reports AIDS cases to the surveillance office.

The average age of these six cases was 37.3 years, over two years above the reported AIDS cases. Two out of the six (33%) were married in contrast to 8% among reported AIDS cases. Two-thirds were white in contrast to 72% for the reported cases. However, it is difficult to draw any conclusions from these comparisons separate from other factors. It may be the case that in some of these instances, demographic characteristics of the case may have played a role in preventing it from being reported, while in other instances, circumstances surrounding the out-of-state diagnosis led those involved to believe the case had either already been reported or did not need to be reported.

Summary and Conclusion

Since the purpose of this study was to evaluate the effectiveness of the AIDS surveillance system in Ohio, any conclusions must address, in quantitative terms, the number of cases overlooked in comparison to those reported:

1) A review of death certificates for 1984, 1985 and 1986 revealed that only six cases *specifically* diagnosed as AIDS on the certificate were missed by the surveillance system.
2) A review of 331 death certificates in which the cause of death was attributed to a disease and/or condition commonly associated with AIDS produced no cases where the actual diagnosis was likely to have been AIDS, and only 11 remotely possible cases were detected.

The best case scenario is that the system was able to identify 97% (199 of 205) of those cases occurring in 1984 through 1986 in which the cause of death was clearly AIDS. This is represented by the diagram on the upper half of Table 4. Thus, if the 205 AIDS cases identified truly represent 100% of the cases then the fact that only six were not previously identified represents only 3% not detected. The system detected 90% in 1985 and 100% in both 1984 and 1986.

Another possibility is that all 11 cases suggestive of AIDS were, in fact, unreported cases of AIDS, regardless of the use or results of the HIV test. These, when added to the 205 known AIDS cases would make a total of 216 cases. With 199 of 216 (92%) cases detected, as illustrated by the lower diagram on Table 4, one might observe this a less optimum scenario. However, this is not likely as none of these cases met the 1987 AIDS case definition, the most sensitive of the AIDS case definitions to date. In addition, these cases were reviewed by staff at CDC responsible for implementing and maintaining AIDS surveillance guidelines.

Of course, it is possible that additional cases may have been missed among those deaths occurring in hospitals whose surveys were not returned or for those having no medical record, or among those deaths occurring in either nursing homes or private residences. Yet, finding a significant number of cases seems unlikely given that all the deaths identified as possible AIDS were found not to meet the case definition. In addition, the deaths occurring outside hospitals tended to be older and had died from more discernible causes such as cancer.

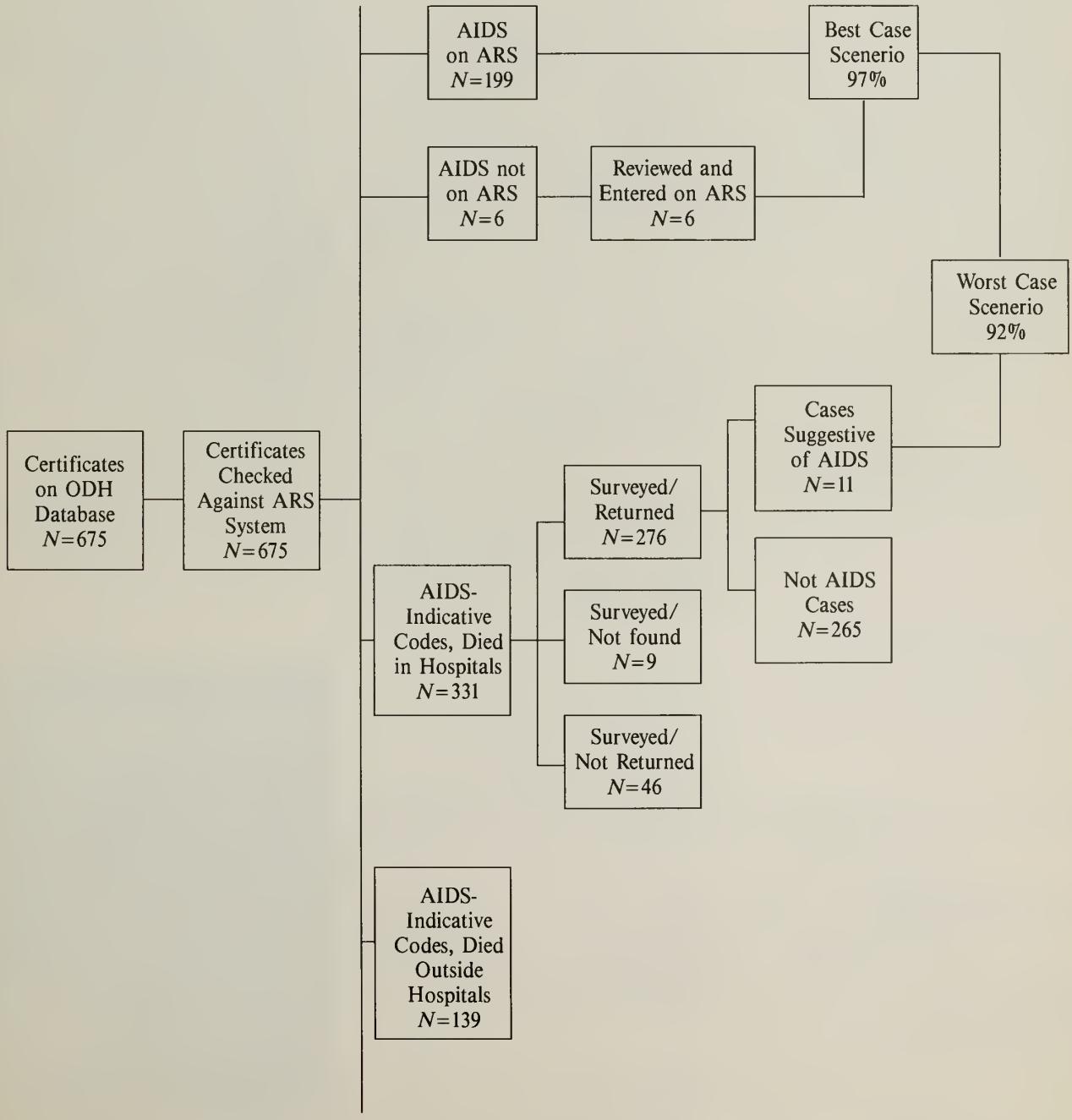
This is the first death certificate study of which we are aware to use the 1987 case definition revision as a standard. Using this definition, being somewhat more liberal than previous versions, one might have expected to find cases that met the 1987 definition that did not meet previous versions, thereby appearing to decrease the completeness of reporting. This was not found to be the case, therefore we can state that applying the 1987 case definition revision to deaths occurring during 1984-1986, before its implementation had no apparent impact on the number of AIDS cases detected in Ohio during these years.

The likelihood that the data are greater than 90% complete suggests that health professionals in the United States, and particularly in Ohio, have a powerful tool to use in planning prevention strategies and health delivery systems. It also helps to assure the general public that information about AIDS transmission based on surveillance data is relatively unbiased and is in fact a fairly complete account of numbers of cases and trends among various groups having AIDS.

The authors would like to thank each of the physicians and ICPs who routinely report AIDS cases, without whom our system could not approach such completeness, and especially to those who participated in this special study by reviewing additional medical records and returning the needed information. Also, thank you to Kathy Rausch and Richard Selik, MD, CDC, for their advice and consultation on the design and evaluation of the study. A special thank you also to Donna Atkins for her assistance in manuscript preparation.

Table 4

Diagram of Death Certificate Review Process and Outcomes Retrospective Death Certificate Study of AIDS and AIDS-Related Conditions in Ohio: 1984-1986



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OHIO, NORTHEAST/CLEVELAND: Emergency department physicians needed for 40,000+ patient volume hospital emergency department in Greater Cleveland area. Physician must be Board-certified in emergency medicine, residency-trained in emergency medicine, or be Board-prepared in emergency medicine. Salary and benefits package worth $130K. Included is liability, disability and life insurance, retirement program, vacation, continuing education and comprehensive health coverage. Full partnership eligibility in two years. Interested individuals, please submit CV to: P.O. Box 2600, Lakewood, OH 44107.

PHYSICIANS NEEDED — Internal medicine, family practice, oncology, endocrinology, neurology, neurosurgery, orthopedic surgery and rheumatology. Group practice, solo or urgent care settings available through our acute care hospital network located in Macon and serving all of middle Georgia. Your practice will be located 80 miles south of Atlanta in a growing family-oriented community, where you can avoid traffic and enjoy a rewarding professional career. Please contact Stephen Wofford collect at (912) 741-6283 for a confidential consultation or write to Stephen Wofford, Director of Physician Recruiting, Charter Northside Hospital, P.O. Box 4627, Macon, GA 31208.

PHYSICIAN—HEALTH SERVICE, THE OHIO STATE UNIVERSITY—The University Health Service of The Ohio State University is seeking a physician to examine and diagnose patients and prescribe medication and treatment. This individual will supervise staff, students and residents, participate in clinical research programs, provide consultation regarding clinical occupational health practices, and develop and update occupational health programs. Candidates must have an MD degree and license to practice medicine in the state of Ohio. Experience in occupational and/or preventive medicine is desired. Salary: $65,040. Apply to D.I. Charles, MD, Director, The Ohio State University Health Service, 1875 Millikin Road, Columbus, OH 43210. An Equal Opportunity, Affirmative Action Employer.

PSYCHIATRIST — Immediate opening for staff psychiatrists, full time and part time, Board-eligible/Board-certified, in a JCAH-accredited, 379-bed inpatient psychiatric hospital. Multidiscipline approach with psychiatrist as a treatment team leader, expected to exercise strong leadership in quality care of patients. Programs for admissions, extended care, geriatrics and psychiatric rehabilitation. License to practice in the state of Ohio is required. Excellent salary and fringe benefits, including paid vacation and personal leave, sick and educational leave, health, vision, dental and life insurance, and Public Employees' Retirement System. Contracts are available. Travel costs may be negotiated. EEO Employer, M/F/H. Send resume to W.J. Roberts, Director of Personnel, or Nathanael Sidharta, MD, Medical Director, Box 540, Massillon, OH 44648, or call (216) 833-3135, ext. 223 or 229.

PSYCHIATRIC POSITIONS. Annashae Corporation is a recognized leader in health-care management and staffing. If you are seeking a change or just starting out we encourage you to write or call us. We currently have openings in Ohio, Mississippi, Illinois, Virginia, Pennsylvania and other states. We offer competitive salaries, pleasant community settings, professional environments, full- and part-time openings and the opportunity to establish a private practice. Contact Annashae Corporation, 6593 Wilson Mills Rd., Mayfield Village, OH 44143-3404; (216) 449-2662. All inquiries are held in confidence.

FAMILY PRACTICE PHYSICIAN — Unparalleled opportunity now exists in Van Wert, Ohio. A very successful practice in a beautiful progressive town of 15,000 (referral area 70,000) can quickly be established. Medical staff very receptive, will offer coverage and call. Excellent schools, recreational and cultural facilities, close to major cities. A family-oriented community that needs an additional family practice physician. Contact or send CV to Rick Addis, Van Wert County Hospital, 1250 S. Washington, Van Wert, OH 45891, phone (419) 238-2390 or home (419) 238-9739.

Equipment

EQUIPMENT FOR SALE — Lifepak 6 defibrillator/EKG, excellent condition. Recent maintenance check. Enochs exam table 27″×51″×33″, foot extension, stirrups, side and end drawers. Head elevates. Green. For information (216) 497-1161, Mrs. Linn.

Miscellaneous

FOR PHYSICIANS: Unsecured signature loans, $5,000-$60,000. For taxes, debt refinance, investments, etc. No points or fees, competitive rates, up to six years to repay. Call toll free 1-800-331-4952, MediVersal Dept. 114.

Practice for Sale

INTERNAL MEDICINE — Practice for sale. Physician retiring after 38 years wishes to sell successful practice. Excellent opportunity for Board-eligible or Board-certified physician in internal medicine/cardiology. Located in S.W. Ohio. Practice is associated with four area hospitals and has an excellent referral system. Interested parties may contact Mr. Gary Geiss, 3052 Queen City Ave., Cincinnati, OH 45238.

SALE OR PARTNERSHIP — Solo practice, northeastern Ohio. Combined general surgery, general practice and industrial. Purchase or partnership arrangements are flexible and negotiable. Call (216) 354-3100.

THE BEST OF BOTH WORLDS is the only way to describe this family practice opportunity. Live and practice in a rural community and yet be just 20 minutes from Columbus. Assume a retiring physician's successful practice and develop it into your own. Finances will be arranged. Contact Robert Young, MD at 882-2294.

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OCCUPATIONAL MEDICINE TRAINING. Intensive program beginning June 4-15, 1990 and continuing October 15-19, 1990 and one week from March 18-22, 1991. The one week continuation portions may be taken in successive years. Clinical and administrative occupational medicine, epidemiology and biostatistics, industrial hygiene, toxicology, regulations, etc. 111 Cat. 2-D CME credits. 14th year. References from past participants provided. $725 per week. Douglas Linz, MD, College of Medicine, M.L. 182, Cincinnati, OH 45267, (513) 558-0046.

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Listed below are the OSMA Councilors and the districts they represent. If you have any questions or concerns regarding OSMA, please address them to your Councilor.

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2905 Burnet Avenue
Cincinnati, Ohio 45219
Adams, Brown, Butler, Clermont, Clinton, Hamilton, Highland, and Warren

Second District
Walter A. Reiling, Jr., MD
2200 Philadelphia Drive, Suite 548
Dayton, Ohio 45406
Champaign, Clark, Darke, Greene, Miami, Montgomery, Preble, and Shelby

Third District
William H. Kose, MD
200 W. Pearl Street
Findlay, Ohio 45840-1394
Allen, Auglaize, Crawford, Hancock, Hardin, Logan, Marion, Mercer, Seneca, Van Wert, and Wyandot

Fourth District
Su-Pa Kang, MD
3900 Sunforest Court, Suite 104
Toledo, Ohio 43623-4498
Defiance, Fulton, Henry, Lucas, Ottawa, Paulding, Putnam, Sandusky, Williams, and Wood

Fifth District
Henry G. Krueger, MD
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North Olmsted, Ohio 44070
Ashtabula, Cuyahoga, Geauga, and Lake

Sixth District
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985 Sawberg Avenue, NE
Alliance, Ohio 44601-3590
Columbiana, Mahoning, Stark, and Trumbull

Seventh District
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Martins Ferry Hospital
92 North 4th Street
Martins Ferry, Ohio 43935
Belmont, Carroll, Coshocton, Harrison, Jefferson, Monroe and Tuscarawas

Eighth District
John F. Kroner, Jr., MD
Box 708
Athens, Ohio 45701
Athens, Fairfield, Guernsey, Licking, Morgan, Muskingum, Noble, Perry, and Washington

Ninth District
Richard Villarreal, MD
613 Center Street
Wheelersburg, Ohio 45694-1795
Gallia, Hocking, Jackson, Lawrence, Meigs, Pike, Scioto, and Vinton

Tenth District
Claire V. Wolfe, MD
793 West State Street
Columbus, Ohio 43222
Delaware, Fayette, Franklin, Knox, Madison, Morrow, Pickaway, Ross, and Union

Eleventh District
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13906 W. Lake Road
Vermilion, Ohio 44089
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The American Medical Association achieved major victories during the 100th Congress, and we have only our members to thank. With their help, the AMA achieved victories for **all** physicians.

- Defeated mandatory Medicare assignment three times in the House Ways and Means Committee;
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Thank you, AMA members, for these and other achievements. We trust we've earned your continued support.

If you aren't an AMA member, join us now. There's much more to be done ...and with your help, no limit to what we can accomplish. **CALL TODAY FOR INFORMATION: 1-800-AMA-1452.**

PROMOTE AIDS EDUCATION

AMA MEDICAL STUDENT SECTION T-SHIRT SALE

Wear the t-shirt that promotes AIDS education. The t-shirts' slogan "**Spread the Word, Not the Disease - AIDS**" reflects the Medical Student Section's ongoing commitment to AIDS education. The Section sponsors a community action program "AIDS Education: Medical Students Respond" through which medical students help educate adolescents about AIDS.

The t-shirts are bright red and are available in sizes large and extra large.

Please enclose a $10.00 donation (per shirt) to the AMA-MSS/AMA-ERF International Scholars Fund. Price includes postage and handling. All proceeds will benefit the Scholars Fund.

AMA-MSS/AMA-ERF
International Scholars Fund
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Chicago, IL 60659

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Check enclosed for $_____

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OSMA Notebook

Durable power of attorney form available — The OSMA has developed a brochure and form for patients that will allow them to draft a durable power of attorney for health care. This form, which can be used in lieu of a living will, permits the patient to legally name someone to make medical decisions for them should they become incompetent. This document became legal on September 27 when SB 13, sponsored by Senator Rick Pfeiffer (D-Columbus), became effective. The OSMA is providing all members with a supply of these brochures, entitled "Health-Care Decisions: Who Makes Them When You Can't?" free of charge to distribute to patients. A sample copy of the brochure and order form were included in the October *OSMAgram*. If you have questions regarding the durable power of attorney legislation contact the OSMA Department of Legislation. The OSMA is working with state aging groups and Sen. Pfeiffer to develop a wider distribution system for these brochures.

Department of insurance completes hearings on health insurance — The Ohio Department of Insurance has completed a series of eight regional public hearings on the issue of health insurance. George Fabe, director of the Ohio Department of Insurance, convened the hearings to address what he had labeled "a health insurance crisis." The OSMA worked with county medical societies to make certain that physicians were present to testify at each hearing. Representatives of Ohio Citizens Action, the group that is the main proponent of the universal health insurance legislation, used the hearing process as a method of publicizing and supporting universal health care. Most of the physicians who testified acknowledged problems within the present health-care system but felt strongly that universal health care was not the answer. Now that the hearings are over, Fabe has indicated that he plans to establish a "blue ribbon" panel to review the testimony and investigate this issue further. The OSMA is working to help assure that a physician will be appointed to this panel.

Candidates nominated — At its most recent meeting, Council voted with the recommendation of the OSMA delegation to renominate Ray Gifford, MD, to the AMA Board of Trustees. In addition, Council approved the nomination of Herman I. Abromowitz, MD, Dayton, to the AMA Council of Medical Services, and Claire Wolfe, MD, Columbus, to the AMA Council of Legislation. In addition, Council approved the nomination of Jerome Kimmelman, MD, Toledo, for a seat on the AMPAC Board.

OSMA adopts gender-neutral policy — The OSMA Council voted recently, at the recommendation of the association's Communications Committee, to adopt a policy of using gender-neutral language in official publications and for public spokespersons. This action was taken as the result of OSMA House of Delegates Resolution 45-89 which was referred to Council by the House. Following is the text of the policy statement: It is the policy of the Ohio State Medical Association that, effective January 1, 1990, all official publications of the association will contain gender-neutral language where appropriate and furthermore, that all official spokespersons for the OSMA will be advised to utilize gender-neutral language when speaking on behalf of the association. OSMA staff has developed guidelines (see page 944) for physicians to help them correctly use gender-neutral language. The original resolution also called for referral to the AMA House of Delegates, so upon adoption of the gender-neutral policy, Council voted to refer the resolution to the AMA.

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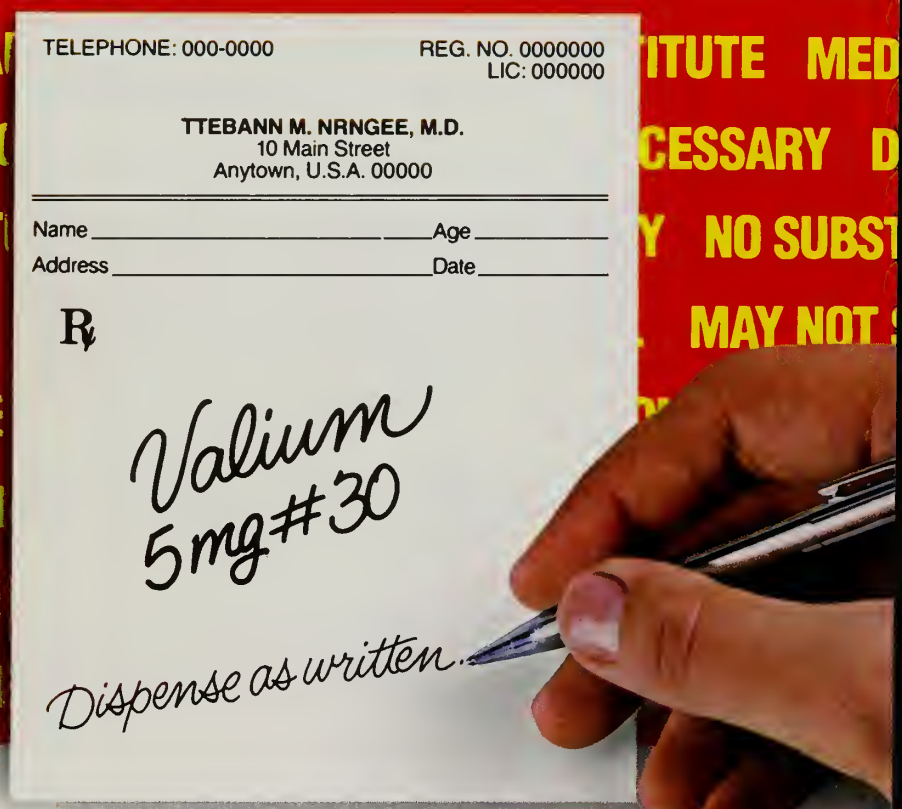

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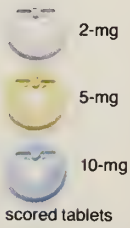

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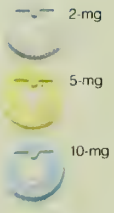

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